South African National Medical Male Circumcision Demand Generation Strategy

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ACRONYMS

ACSM	Advocacy, Communication and Social Mobilisation
AIDS	Acquired Immune Deficiency Syndrome
AYFS	Adolescent and youth-friendly services
ART	Antiretroviral therapy
BMGF	Bill and Melinda Gates Foundation
CCG	Community care givers
CDC	Centres for Disease Control
CHAI	Clinton Health Access Initiative
CHW	Community health workers
CoGTA	Cooperative Governance Traditional Affairs
DBE	Department of Basic Education
DCS	Department of Correctional Services
DHIS	District Health Information System
DHP	District health plans
DIP	District implementation plan
DJ	Disc jockey
DMPPT	Decision-Makers' Program Planning Toolkit
DoD	Department of Defence
DPSA	Department of Public Service and Administration
FAQ	Frequently asked question
GF	The Global Fund to Fight AIDS, Tuberculosis and Malaria
HAST	HIV, AIDS, STIs and TB
HIV	Human Immunodeficiency Virus
HEAIDS	Higher Education and Training HIV/AIDS Programme
IEC	Information, education and communication
IPC	Interpersonal communication
HTS	HIV testing services
MMC	Medical male circumcision
NDoH	National Department of Health
NDP	National Development Plan
NSP	National Strategic Plan for HIV, TB and STIs 2017 - 2022
OOH	Out-of-home
PEPFAR	President's Emergency Plan for AIDS Relief
PHC	Primary healthcare
PHCWBOT	Primary healthcare ward-based outreach teams
PRO	Public relations officer
SAARF	South African Audience Research Foundation
SABC	South African Broadcasting Corporation
SABCOHA	South African Business Coalition on HIV/AIDS
SANAC	South African National AIDS Council
STI	Sexually transmitted infection
TB	Tuberculosis
TVET	Technical Vocational Education and Training
UNAIDS	United Nations Programme on HIV/AIDS
WHO	World Health Organisation

EXECUTIVE SUMMARY

Demand generation for medical male circumcision (MMC) is the process by which prospective uncircumcised and HIV negative clients, and their social influencers obtain knowledge about, understand the benefits of, make the decision to undergo and become champions for MMC. The national MMC demand-generation strategy is a resource that will guide those who strive to generate demand for MMC, do so in the most effective manner. This strategy emphasises integration of MMC as a part of a comprehensive sexual reproductive health package of services for men and understanding how to bridge the gap between men intending to get medically circumcised and ultimately going for the procedure. The strategy will assist in strengthening methodologies, increasing coordination and decentralising implementation. This document has been developed for use by a wide range of individuals working in the MMC programme.

MMC demand-generation activities and approaches detailed in this strategy aim to contribute directly to the achievement of the national goal of 2.5 million procedures by 2022 among HIV-negative men aged 15-49 years who are at high-risk of contracting HIV.

SITUATION ANALYSIS

The situation analysis examines four main questions regarding the South African MMC programme:

1. What are we trying to achieve as a country?
2. What is the history of the programme?
3. What are the gaps and challenges in demand generation?
4. How does this strategy align with other men's health programmes?

It is understood that MMC is a key intervention for HIV prevention and reduction of new infections. Research conducted in South Africa, Uganda and Kenya has demonstrated that MMC reduces the risk of female-to-male sexual HIV transmission by approximately 60% (8-10). In South Africa, modelling data suggest that for every 10 medical male circumcisions, one new HIV infection may be prevented (11). This will help reduce community-level HIV incidence, and lead to savings in HIV care and treatment costs.

The current National Strategic Plan for HIV, TB and STIs 2017 - 2022 (NSP) recommends offering MMC as part of a comprehensive package of sexual and reproductive health services (2). South Africa's strategic goal is to contribute to the reduction of HIV incidence by scaling up MMC as part of combination HIV prevention to reach 80% of HIV negative men aged between 15 - 49 years.

While the MMC programme performance accelerated quickly in its early years beginning in 2010, it has now fallen short of annual targets in more recent years. Generating demand for MMC is crucial to the success of the programme. South Africa continues to experience challenges in converting men's intention to undergo medical circumcision into the actions of making an appointment and utilising MMC services.

It is the goal of this strategy to help coordinate and improve national MMC demand-generation efforts in order to reach MMC targets. South Africa's National Development Plan (NDP) prioritises the improvement of preventive and therapeutic interventions to reduce HIV (26). For many men, accessing MMC services may be their first contact with the health services and it presents an opportunity to address other aspects of men's sexual and reproductive health.

THEORY OF CHANGE

This strategy is based on a theory of change for demand generation which focuses on the factors that constitute barriers to and enablers of MMC. Demand-generation activities lead to short-term and intermediate outcomes which ultimately lead to the increased uptake of MMC. The theory of change helps understand the process by which demand-generation activities contributes to the long-term goal of reducing new infections to less 88,000 per year by 2022.

The main focus of demand-generation activities is to reduce ideational (relating to knowledge, beliefs, attitudes and perceptions) barriers to MMC and strengthen enablers. Demand-generation activities are not only aimed at generating demand for MMC but also at creating an enabling environment in which men can access sexual reproductive health services, including MMC. Structural barriers (such as the availability, accessibility and affordability of services) need to be addressed in a holistic manner by all stakeholders in the MMC programme.

TARGET AUDIENCE

Aligned to the NSP, the demand-generation strategy also follows a “focus for impact” approach in locating, understanding and supporting uncircumcised men with the ultimate goal of enabling them to undergo MMC. This concept is based on the epidemiology of HIV which shows great variation in the burden of diseases across different regions and districts of South Africa.

South Africa has a diverse population incorporating different cultures and social norms. This gives rise to distinct requirements for demand generation in various geographic areas. Demand-generation efforts need to focus on areas where there are large numbers of uncircumcised men. It is essential to understand where men congregate in specific geographic areas.

While uncircumcised, HIV-negative men aged 20-34 are the primary audience of MMC demand-generation activities, social influencers are a secondary target audience who can have a critical impact on a man’s decision to undergo MMC. These influencers include male peers, romantic partners, family members and individuals in the community (12). Their support – or lack of support – can be a decisive factor in men’s choice whether to medically circumcise (13). Demand-generation activities must therefore seek to enhance support for MMC among individuals who have potential to influence men who are considering MMC (14).

TAILORING THE MESSAGE

Once the target audience has been identified, their particular knowledge levels, beliefs, attitudes and social pressures must be understood in order to deliver the right message that will address these and move men who intend to medically circumcise to actually undertake the procedure. The messages must resonate with the men we hope to persuade to opt for MMC.

This strategy utilises the Stages of Change Model to chart the journey to MMC. The model assumes that people do not change their behaviours quickly and decisively but instead move through defined stages to new behaviour. The strategy applies this model to MMC and provides detailed messages for each stage and breaks down barriers at each stage of the decision-making process.

COMMUNICATION METHODS

South Africa is a media-rich environment, meaning there are many avenues in which MMC can be advertised, however it is a very competitive landscape. There are various communication methods

available for use in South Africa (such as television, radio, out-of-home advertising, social mobilisation, etc.) that can be used to convey messages both to the primary audience of men in the priority age range and to the wider secondary audience of influencers.

To select appropriate channels in a resource-constrained environment, it is important to consider the knowledge of the audience and the information to be conveyed. In order to deploy the various channels in an organised manner, it is necessary to develop an implementation plan that specifies:

- The sequence and frequency of interventions,
- The audience they expect to reach,
- The messages to be conveyed, and
- Those responsible for implementation and the required resources.

Communication planning needs to be an integrated activity at national, provincial, district and local level. Planning of national and regional mass media activities will rest with the NDoH, the Phila initiative and provincial health departments, while the use of community media and fine-tuning of inter-personal communication will rest with districts and individual MMC facilities.

MANAGING THE RESPONSE

Monitoring the effectiveness of demand-generation activities is linked directly to the theory of change. Each outcome from the theory of change has related indicators that can be appropriately tracked to establish the success of the programme. The overarching monitoring questions of the programme are:

- What is the number and percentage of men reached by social mobilisers?
- What number and percentage of men have been successfully booked for MMC services by social mobilisers?
- What number and percentage of men have been successfully booked for MMC services by call centre agents?
- What is the number and reach of community-based media campaigns aimed at generating demand for MMC, per campaign type?
- What is the number and reach of national mass media campaigns aimed at generating demand for MMC, per campaign type?
- What is the number of meaningful engagements with national social media campaigns developed to generate demand for MMC?

GOVERNANCE

This strategy provides a structure for reporting and roles and responsibilities for all levels of the programme in order to create a transparent line of accountability across the programme. The coordination of implementers is essential to avoid duplication and maximise results.

The NDoH will be tasked with conducting quarterly meetings of the National Demand Generation Working Group to coordinate and monitor the implementation of the MMC Demand-Generation Strategy and its effectiveness. Information regarding the composition and tasks given to the working group are detailed in section 8 of this document.

COSTING

The cost of demand-generation activities is very important for implementers to understand in order to appropriately plan and successfully execute. It is important to note that costs will vary based on the province and district and costs outlined in this strategy should be considered as a guideline.

1. SITUATION ANALYSIS

This demand-generation strategy for medical male circumcision (MMC) is a document intended as a practical tool to produce a more coherent approach to demand generation among the many role-players that contribute to this function. Broadly, demand generation can be defined as the focus of targeted marketing programmes to drive awareness and interest in a product and/or service, in this context, for MMC. The strategy also draws together evidence on effective approaches to promoting MMC uptake and presents an approach designed to standardise and improve demand-generation practice.

1.1. WHAT ARE WE TRYING TO ACHIEVE AS A COUNTRY?

South Africa has 7.1 million people living with HIV. This translates to a national prevalence rate of 12.8%, rising to 19.1% among those between the ages of 15-19 years (2). The number of new infections remains high. In 2016, 270 000 people were newly infected with HIV (7).

MMC is a key intervention for HIV prevention and reduction of new infections. Research conducted in South Africa, Uganda and Kenya has demonstrated that MMC reduces the risk of female-to-male sexual HIV transmission by approximately 60% (8-10). Mathematical models estimate that rapidly improving uptake of MMC in a large number of uncircumcised men in strategically chosen populations may dramatically reduce community-level HIV incidence, saving billions of public healthcare investment and HIV care and treatment costs. In South Africa, modelling data suggest that for every 10 medical male circumcisions, one new HIV infection may be prevented (11).

In 2007 The World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) called for the scale-up of MMC in priority countries with high HIV prevalence rates. South Africa is one of these countries, as it has the largest HIV epidemic in the world (15).

Global HIV prevention targets aim to provide MMC to 3 million men in high-incidence countries by 2018-2022 (16). In addition, the UNAIDS 2016 - 2021 strategic framework for MMC aims to reach 90% of males aged 10-29 years in priority settings in sub-Saharan Africa by 2021 (16, 17).

South Africa began providing MMC in 2010, and the National Strategic Plan for HIV, TB and STIs 2017 - 2022 (NSP) recommends offering MMC as part of a comprehensive package of sexual and reproductive health services (2). South Africa's strategic goal is to contribute to the reduction of HIV incidence by scaling up MMC as part of combination HIV prevention to reach 80% of HIV negative men aged between 15 - 49 years. Consequently, as indicated in the NSP, the National Department of Health (NDoH) MMC programme aims to provide MMC to 2.5 million men between 2017 - 2022. Scale-up efforts have been divided into two phases:

- The catch-up phase for rapid achievement of 80% coverage of adult men in high risk age groups (2).
- The sustainability phase during which 80% coverage would be maintained by offering medical circumcision routinely to adolescents and infants (2).

The NSP has also identified 27 priority districts across South Africa which accommodate 82% of all people living with HIV and account for a high proportion of new infections (5). These districts are listed along with low-burden districts in the same province in Table 1.

Table 1: List of districts with high and lower burden of HIV infections

Province	High-burden districts	Lower-burden districts
Gauteng	City of Johannesburg Ekurhuleni City of Tshwane Sedibeng	West Rand
Kwa-Zulu Natal	eThekwini uMgungundlovu King Cetshwayo Zululand uGu uThukela Harry Gwala	uMkhanyakude Amajuba uMzinyathi iLembe
Mpumalanga	Ehlanzeni Nkangala Gert Sibande	
Eastern Cape	OR Tambo Amathole Alfred Nzo Chris Hani Buffalo City	Nelson Mandela Bay Joe Gqabi Sarah Baartman
Free State	Thabo Mofutsanyana Lejweleputswa	Mangaung Fezile Dabi Xhariep
North West	Bojanala Platinum Ngaka Modiri Molema Dr Kenneth Kaunda	Ruth Segomotsi Mompati
Limpopo	Capricorn Mopani	Waterberg Sekhukhune Vhembe
Western Cape	City of Cape Town	Central Karoo Cape Winelands Overberg Eden West Coast
Northern Cape		Namakwa Frances Baard John Taolo Gaetsewe Zwelentlanga Fatman Mgcawu Pixley ka Seme

1.2. WHAT IS THE HISTORY OF THE PROGRAMME?

The South African national MMC programme was initiated in early 2010 and performed about 140 000 MMCs that year through a pilot project conducted in partnership with the United States Government and the President's Emergency Plan for AIDS Relief (PEPFAR).

In 2011, the NDoH guided a process of programme expansion resulting in more than 340 000 MMC procedures conducted for that year. While performance has accelerated quickly, it has fallen short of annual targets. As of November 2017, the programme had achieved a total of 3 211 119 MMCs since inception (18).

Demand generation serves as the foundation of the MMC programme, where demand is passively and actively created using several modalities.

Communication interventions have addressed practical and ideational barriers to MMC and aimed to assist men to overcome these. Communication campaigns have increased awareness and knowledge of the benefits of MMC. They have positioned MMC as aspirational and used various communication channels to inform men about the benefits of MMC. Table 2 summarises the impact of communication interventions on knowledge of MMC and intention to undergo MMC among men in South Africa.

Table 2: **Knowledge of MMC in SA and intention to circumcise, 2012 -2016**

Concept	% of population
Male knowledge of benefits of MMC	51%(19)
Male knowledge of circumcision as HIV prevention	48%(20)
Knowledge of continued condom use after circumcision (includes men and women)	84%(21)
Male knowledge of waiting period before having sex	34%(21)
Intention to circumcise	28%(19)

While there has been an overall increase in public knowledge of the benefits of MMC, intention to undergo MMC is not as high even though people understand the benefits. South Africa continues to experience challenges in converting men's intention to undergo MMC into the actions of making an appointment and utilising MMC services. This implies a need to strengthen the MMC programme in order to increase the uptake of MMC.

In leading the MMC programme, the NDoH is responsible for policy development and oversight of implementation. The department has financial and technical support from bilateral and multilateral development partners, such as PEPFAR and the Bill and Melinda Gates Foundation (BMGF). PEPFAR has funded a number of implementing partners that provide demand-generation and medical circumcision services. Additional support is received from WHO, UNAIDS and the Global Fund to Fight HIV, TB and Malaria (GF). Implementing partners also provide technical input on research, evaluation and innovation.

Figure 1 depicts major milestones in the development of MMC services in South Africa.

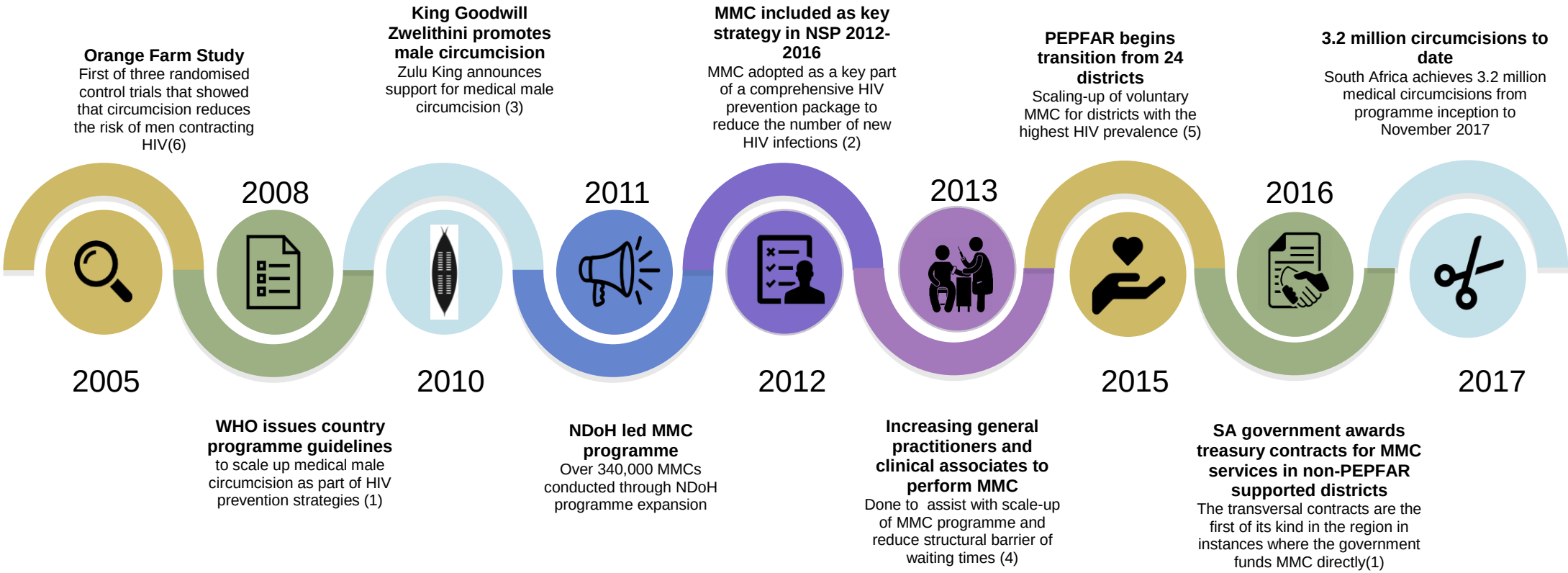


Figure 1: Timeline of MMC programme progress to date

1.3. WHAT ARE THE GAPS AND CHALLENGES IN DEMAND GENERATION?

Recent research shows that there is fairly high awareness of the health benefits of MMC among men and women in South Africa (22). This includes awareness of its role in reducing the risk of HIV and other sexually transmitted infections (STIs). However, while the total number of MMC procedures has increased each year, the rate of MMC uptake has decreased significantly.

Earlier MMC communication campaigns were very effective in engaging the early adopters (those who circumcised) of MMC – mainly adolescents aged 10-14 years – and now the challenge is to persuade more apprehensive, late adopters of the service. Members of the latter group are hesitant to utilise MMC services due to some persistent barriers, including:

- Fear of pain.
- Anxiety about getting tested for HIV.
- The period of sexual abstinence after MMC.
- Getting time off work for MMC and loss of wages.
- Anxiety about the response of family, friends, colleagues and others.
- Female service providers and perceptions that health facilities are for women.
- Lack of partner support.
- Inconvenient service hours.
- The idea that healing is easier in winter.

There is also a gap in service providers' systematic understanding of barriers to MMC and factors that might motivate individuals to undergo MMC. As a result, there is a lack of guidance to social mobilisation teams across the country on how to approach men at different stages of decision making.

Other factors contributing to the decrease in uptake of MMC services include poor buy-in from the traditional sector, the move away from focusing on 10-14-year-old males, as well as the lack of a clear national strategy for promoting MMC to older men. The decrease can further be attributed to inadequate funding, limited implementation of activities to create demand for MMC and negative media reports about MMC. Furthermore, several cultures in South Africa practice traditional circumcision as part of a cultural rite of passage, and this practice often prohibits traditional initiates from undertaking MMC.

Additional significant gaps identified in the programme are:

- Poor support for the MMC programme by male-dominated industries.
- Inadequate coordination of demand-generation activities between the NDoH and its partners.
- Poor monitoring of demand-generation activities by public health sector social mobilisers working across organisations and supporting multiple health programmes.
- A lack of coordination and management of mobilisers and mobilisation activities.
- An inadequate supply of information, education and communication (IEC) materials as well as limited mass media communication.
- An insufficient number of mobilisers with the skills to conduct demand-generation activities for MMC in an effective manner.
- The lack of standardised training for MMC demand generation.
- The absence of a monitoring and evaluation (M&E) system or tools to measure the effectiveness of demand-generation activities.
- Poor planning by provinces to support demand-generation activities for MMC.

- Budget shifting or failure to allocate budget for demand generation within the public health sector.

1.3.1. Operational issues around demand generation

There are several operational issues that have led to suboptimal demand generation since the inception of the MMC programme.

Inconsistent messaging:
The content of communication materials has not been consistent. There have been instances where content has been inaccurate (for example, describing circumcision as a painless procedure) and this can create mistrust within the audience the programme seeks to influence.

Not targeting adult men:
Demand-generation materials have also failed to address the harder-to-reach audience of adult men. Their messaging lacks the creativity needed to close the intention-action gap and to boost demand in the low-uptake seasons.

Incoordination among stakeholders at local levels:
There is a lack of coordination and standardisation of activities which has resulted in discord among key stakeholders. Although every communication between a mobiliser and prospective client must be tailored to the client's needs, the mobiliser should have received standardised training to produce the most impactful interaction.

Human resources:
There is a need to build human resource capacity in demand generation and MMC management at a provincial, national and district level. Dedication and skill sets among staff vary widely and standardised training could help reduce these gaps. This variability also arises from the fact that the roles of staff responsible exclusively for MMC and the staff of the national and provincial directorate for advocacy, communication and social mobilisation (ACSM) are not clearly defined.

Monitoring and data use:
M&E of demand generation is poor and indicators to drive the programme are unclear. There has been little formative research and impact evaluation to direct the programme. The District Health Information System (DHIS) only measures the number of medical circumcisions performed and does not capture any demand-generation activities. Staff have insufficient training on utilisation of the DHIS and the system is limited in terms of its ability to perform advanced functions and capacity to input data.

1.4. HOW DOES THIS STRATEGY ALIGN WITH OTHER HEALTH PROGRAMMES?

South Africa's National Development Plan (NDP) prioritises the improvement of preventive and therapeutic interventions to reduce HIV (26). Considering the HIV prevention benefit of MMC, it is imperative to establish a standardized, evidence based and South Africa specific demand-generation strategy. Accordingly, this strategy seeks to address this objective, in alignment with the goals of the NDP.

MMC is also a key element of the HIV prevention package outlined in the NSP which envisages MMC as one of the services constituting combination HIV prevention (3). For many men, accessing MMC

services may be their first contact with the health services and it presents an opportunity to address other aspects of men's sexual and reproductive health.

To realise this opportunity, it is necessary to strengthen the integration of the MMC programme with other health programmes such as:

- HIV testing services (HTS).
- Sexually transmitted infections (STIs).
- Condom distribution services.
- Sexual and reproductive health.
- Primary healthcare (PHC) services.
- Adolescent and youth-friendly services (AYFS).
- Maternal and child health.

In order to strengthen collaboration between the MMC programme with each of the above programmes, a series of consultative meetings will need to be conducted. This integration process must be led by the national MMC programme, working together with ACSM and the national health campaign, Phila, at national, provincial and district levels. The goal would be to ensure that MMC is, where possible, aligned with and incorporated into the campaigns and implementation plans of each of these directorates and vice versa.

Generating demand for MMC must be sustainable to contribute towards the target of reducing the number of new HIV infections to zero in South Africa by 2030 (16). This can be achieved by including MMC demand generation in the mandate of primary healthcare ward-based outreach teams (PHCWBOT) and positioning MMC as part of primary healthcare for men, within a package of comprehensive sexual and reproductive health education and services.

2. HOW TO USE THIS DOCUMENT

The national MMC demand-generation strategy is a resource that will guide the NDoH, provincial health departments, other government departments, South African National AIDS Council (SANAC) sectors, funders, implementing partners, HEAIDS, and the religious, traditional and private sectors in maximising the effectiveness of demand-generation activities for MMC. It will assist in strengthening methodologies, increasing coordination and decentralising implementation.

This strategy is a living document that seeks to revitalise the implementation of demand-generation activities. It will therefore be revised periodically to ensure its continued relevance and effectiveness.

MMC activities and approaches detailed in this strategy aim to contribute directly to the achievement of the national goal of 2.5 million procedures between 2017 - 2022 among HIV-negative heterosexual men aged 15-49 years.

The document has been informed by extensive research studies and seeks to offer practitioners practical guidance that is responsive to the current MMC landscape within South Africa. It has been developed for use by a wide range of individuals working in the MMC programme. Below is an outline of the content of the different sections in this strategy document.

- **Section 3**: outlines the theory of change and key objectives of the MMC strategy. The theory of change focuses on the factors that constitute barriers to and enablers of MMC. The overall programmatic goals and objectives, considered together with the theory of change employed in this strategy, give rise to the programme's communication objectives.

- **Sections 4-6:** detail a 'focus for impact' approach to locating, understanding and supporting uncircumcised men with the ultimate goal of enabling them to undergo MMC. This is essential for holistically supporting the programme to increase demand for MMC.

- **Section 7:** provides structured guidance on how to monitor and evaluate the success of the programme at each level of the programme and how data should be used in order to inform and guide improvements to the programme.

- **Section 8:** outlines the government structures for programme management, policies and reporting. It assists all levels of the programme to understand the roles and responsibilities to ensure the success of the programme.

- **Section 9**: provides benchmark costs for the communication channels discussed in section 6 to help implementers understand how to best make use of limited resources.

Table 3 delineates how each stakeholder can utilise this document to enhance his or her area of practice.

Table 3: Usefulness of the document for each stakeholder

Stakeholder	Guidance on how to use this document
National Department of Health	• The MMC and ACSM directorates will use the strategy to provide guidance and support to provincial health departments and other stakeholders and to improve coordination among them. • The strategy will serve as an advocacy tool to forge and strengthen strategic high-level partnerships with other health programmes,

Stakeholder	Guidance on how to use this document
	government departments, funders, SANAC sectors, the Phila campaign, HEAIDS, the private sector, as well as the traditional and religious sectors. • It will assist the NDoH to monitor the implementation and effectiveness of MMC demand generation nationally, holding all stakeholders accountable and troubleshooting where necessary. • Regular technical multi-sectoral meetings will serve as a mechanism for such monitoring.
National Department of Health: Phila campaign	• Phila campaign managers will use this document to guide the development and implementation of all the campaign's MMC demand-generation activities. • The strategy will enable Phila to develop IEC materials suitable for MMC demand generation and marketing of MMC services.
Provincial departments of health	Provincial health officials may utilise the strategy: ▪ To achieve stronger buy-in for the MMC programme among departmental managers at senior, middle and operational level. ▪ As a tool for advocacy and sensitisation activities aimed at improving relationships and addressing a view within the health system that MMC is for implementing partners and is of little benefit to public health services. ▪ To give strategic guidance and clear direction to demand-generation activities in the province. ▪ To promote coordination and integration of demand-generation activities into PHC services and contribute to coordination of MMC services more broadly.
Health districts	The strategy will assist at district health level in: ▪ Building the capacity of district leadership to undertake advocacy within the health department and to the general public. ▪ Planning MMC demand-generation interventions and allocating resources for implementation. ▪ Conducting activities to promote MMC.
Funders	Funders will find the strategy useful in: ▪ Informing their collaboration with the South African Government and guiding their planning so that implementation occurs in a locally acceptable way. ▪ Guiding geographic areas for MMC activities. ▪ Informing DG at local levels and improving efficiencies within the funded programme across partnerships and funding agencies.
Sectors represented on the SANAC	This document will be used by the 18 sectors of SANAC, by sectors represented on provincial, district and local AIDS councils, and by members of ward AIDS committees. It will guide: ▪ Chairpersons of the AIDS Councils as they advocate for MMC. ▪ Various sectors as they develop sector-specific plans for MMC.
Other government departments	This document should be used to provide leadership, and informed guidance on MMC at the highest levels across government departments in order to achieve buy-in and ensure all departments help achieve the ambitious national targets for MMC. • It is a resource that enables government departments to include the promotion of MMC in their mainstreaming of HIV.

Stakeholder	Guidance on how to use this document
HEAIDS	HEAIDS should use this document to: ▪ Facilitate partnerships for MMC demand generation with implementing partners in areas with universities and Technical and Vocational Education Training (TVET) colleges. ▪ Enable peer educators at universities and TVET colleges to act as MMC champions and campus radio stations to promote MMC. ▪ Enable campus healthcare clinics to popularise MMC.
Traditional Sector	▪ This document should be used to engage national and provincial bodies of traditional leaders and enable them to lead the development and implementation of HIV prevention programmes in their constituencies, including the integration of MMC into traditional male initiation.
Religious Sector	• The strategy may enable religious leaders in local communities to act as champions for MMC and overcome some of the barriers encountered in MMC demand generation. • It may facilitate the integration of faith-based organisations into community health activities, for example, wellness days.
Private sector (including workplace MMC programmes)	The private sector will find this document useful to: ▪ Develop workplace policies related to employees' access to MMC services and consequent leave provisions. ▪ Include MMC in their corporate social responsibility programmes – for example, by sponsoring MMC demand-generation campaigns.
Implementation Partners	▪ The strategy facilitates open communication and coordination between implementing partners and the demand-generation activities of various departments of health. ▪ It helps to standardise demand-generation approaches and develop best-practice across the range of MMC implementers. ▪ Aims to improve efficiencies in demand-generation investment and leverage momentum across multi-pronged strategies from partners.

3. KEY OBJECTIVES AND THEORY OF CHANGE

This strategy takes its direction from one of the major goals of the NSP: to reduce new HIV infections from 270 000 a year to fewer than 88 000 by 2022 (2).

These overall programmatic goals and objectives of the NSP, considered together with the theory of change employed in this strategy, give rise to the programme's communication objectives.

3.1. THEORY OF CHANGE

In general, a theory of change is a comprehensive illustration of how and why a desired change is expected to happen in a particular context. In the context of MMC demand generation, the theory of change is focused in particular on mapping out the path of the strategy's change initiative (the refinement of demand-generation activities) and how these lead to the desired goals being achieved. It does this by first identifying the desired long-term impact (reduction of new HIV infections) and then works back from these to identify all the conditions (outcomes) that must be in place (and how these related to one another causally) for the impact to occur. The theory of change for demand generation, depicted in Figure 2, focuses on the factors that constitute barriers to and enablers of MMC.

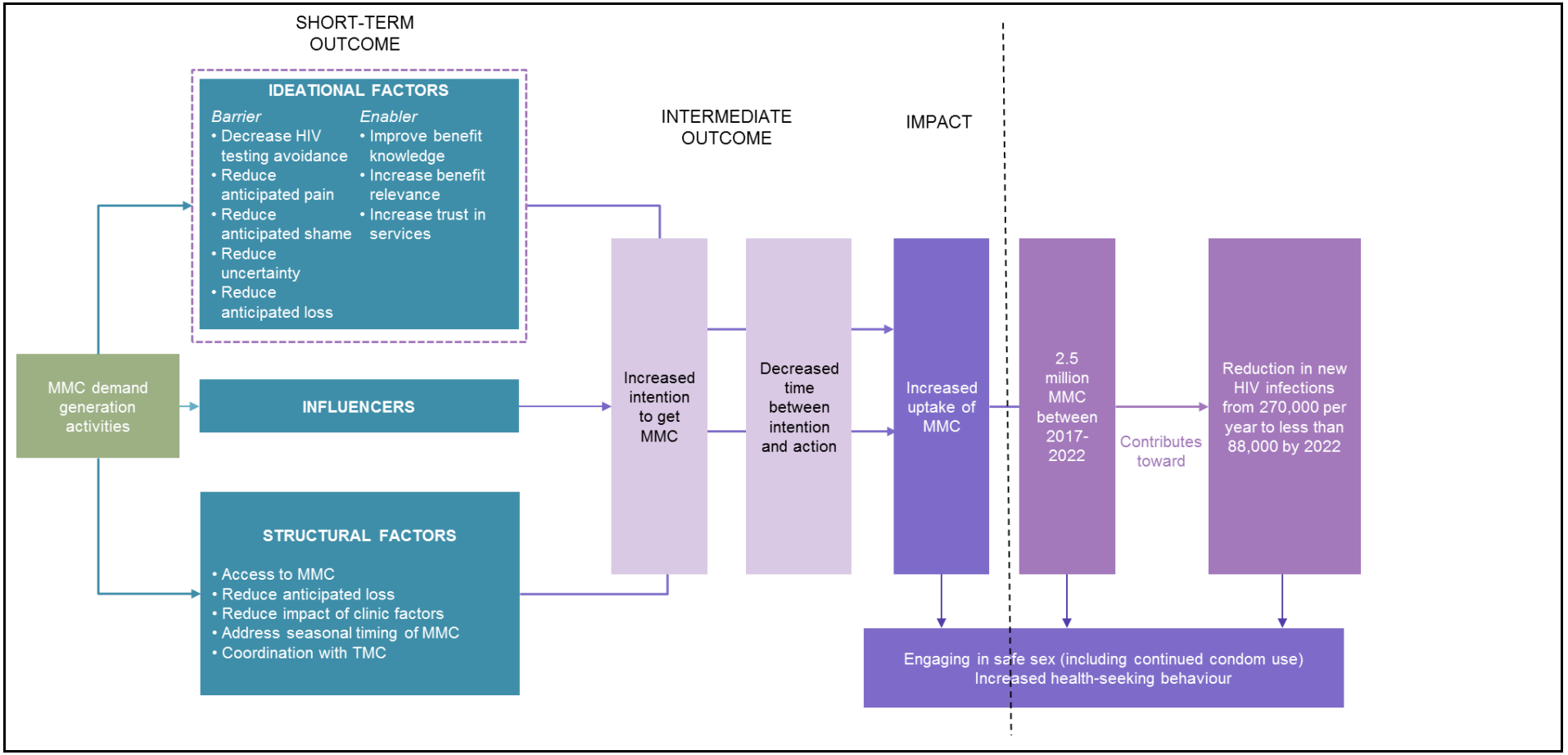
There are two main categories of barriers and enablers: those that are ideational – relating to knowledge, beliefs, attitudes and perceptions – and those that are structural. The latter include factors such as the availability, accessibility, affordability and acceptability of services.

The main focus of demand-generation activities is to reduce ideational barriers to MMC and strengthen enablers. This is achieved by building knowledge, shaping attitudes, beliefs and perceptions, and motivating behaviours that contribute to the achievement of the broader programmatic objective of 2.5 million medical circumcisions between 2017 - 2022.

Influencers as a category are identified as a short-term outcome of MMC demand-generation activities and are further explored in section 4. Barriers and enablers to MMC, established through research, are listed briefly in Figure 2. They are more fully described in section 5 as part of an exploration of how messaging is tailored to deal with the particular enablers and barriers experienced by the various groups of men.

While communication can contribute to a reduction in the structural barriers to MMC, it is not solely responsible for tackling these issues. Structural barriers need to be addressed in a holistic manner by all stakeholders in the MMC programme. Demand-generation activities are not only aimed at generating demand for MMC but also at creating an enabling environment in which men can access MMC services.

The outcomes and impact of the theory of change must be measurable indicators which lay the groundwork for how to monitor and evaluate the programme to ensure that the activities are in fact leading to the desired outcomes. Section 7 discussing managing the response in further detail.



* Area left of the line represents demand generation and the area right of the line represents operations

Figure 2: Theory of change for demand generation

3.2. COMMUNICATION OBJECTIVES

The communication objectives for the national MMC programme, which clearly reflect the underlying theory of change, are to:

1. Increase knowledge of the benefits of MMC.
2. Increase intention to undergo MMC.
3. Reduce the intention-action gap by addressing the ideational barriers.
4. Increase uptake of MMC.
5. Increase knowledge for consistent and correct use of condoms and safe sexual practices.

Although change is not a strictly linear process, generally there would be progress in improving knowledge and building positive sentiment towards MMC before a substantial improvement in the uptake of MMC services occurs.

4. TARGET AUDIENCE

The current NSP has at its core the concept of “focus for impact”. This concept is based on the epidemiology of HIV which shows great variation in the burden of diseases across different regions and districts of South Africa. The demand-generation strategy also follows a “focus for impact” approach in locating, understanding and supporting uncircumcised men with the ultimate goal of enabling them to undergo MMC.

Sections 4, 5 and 6 outline the questions an MMC programme implementer should explore in order to apply this approach.

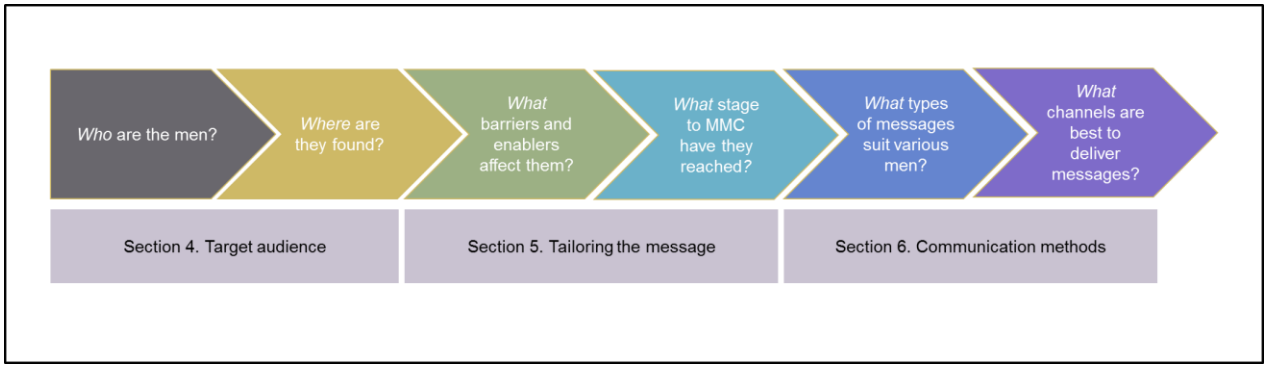


Figure 3: Key questions in applying focus for impact approach to MMC

4.1. WHO ARE THE MEN?

4.1.1. Understanding your context

South Africa has a diverse population incorporating different cultures and social norms. This gives rise to distinct requirements for demand generation in various geographic areas. MMC managers and demand-generation staff must carefully consider the requirements of residents in their catchment areas. Because early MMC adopters of all ages have already been circumcised, as the programme scales up it is important to understand various barriers and enablers men experience, as well as the stage individuals have reached in deciding whether to undergo MMC.

A resource to help understand where uncircumcised men are in a specific geographic area is the Decision-Makers’ Program Planning Toolkit (DMPPT). The DMPPT is a monitoring and planning tool that generates coverage estimates and target and impact projections for the MMC programme down to the district level, disaggregated by five-year age group. It is available through http://avenirhealth.org/policytools/DMPPT2/.

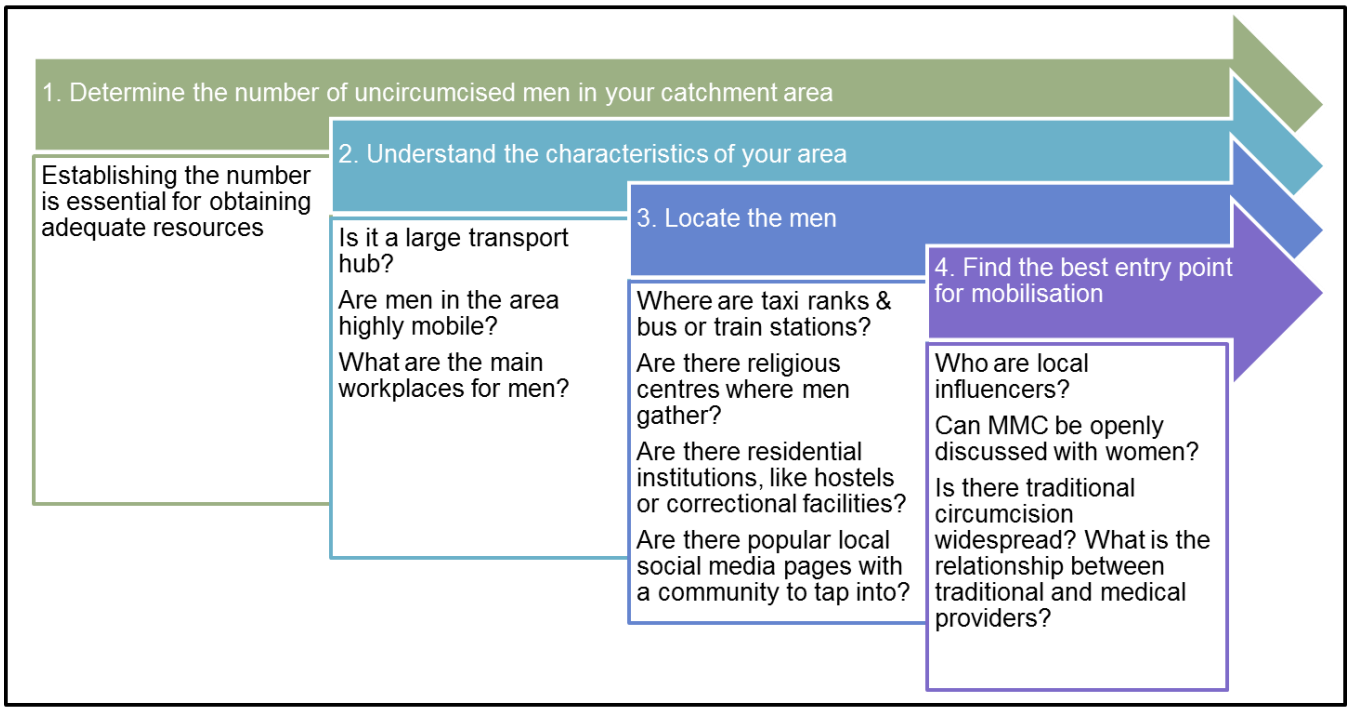


Figure 4: Process for understanding and locating local population of uncircumcised men

4.1.2. Current approach to prioritisation

The broader target population for the programme are uncircumcised, HIV-negative men between the ages of 15-49. The DoH has prioritised men aged 20-34 years for MMC as they are most likely to be sexually active and therefore at higher risk of contracting HIV from an HIV-positive female partner. Focusing on men at high risk of infection will have the greatest impact in terms of reducing the number of new infections in the next five years. The aim is to scale up the MMC programme and reach 80% of men in this age group in a short period of time. Prioritisation of boys aged 10-14 years can increase gradually after this goal has been met. However, MMC services should not be denied to any medically eligible male who presents himself for the service.

Once targets have been met in this priority population, the DoH will transition from a “scale-up” to sustainability phase, and may shift its focus to younger males, including infants.

To date, most clients accessing MMC services have been adolescents aged between 10 years and 19 years. This is possibly because younger men are easier to reach, especially in the school setting, and school-age peers and parents have played a positive role in promoting MMC. In addition, in some South African cultures, male circumcision is part of an adolescent boy’s rite of passage into manhood. There is therefore normative support for the circumcision of adolescents. However, traditional and medical circumcision can be contested and it is important to integrate the two to ensure traditional beliefs are upheld and circumcisions are done safely and correctly. Furthermore, there are some barriers to MMC for adult men – such as absence from work and sexual abstinence during the healing period – are less of an issue for adolescents.

Further discussion of MMC enablers and barriers experienced by men in the priority age group appears in section 5.

4.2. WHERE ARE MEN TO BE FOUND?

Demand-generation efforts need to focus on areas where there are large numbers of uncircumcised men, especially in the 27 HIV high-burden districts (5). It is essential to understand where men congregate in specific geographic areas and the DMPPT (mentioned above) can help determine this.

4.2.1. High-burden districts

During the next five years the aim is to saturate high-burden districts with HIV services, while continuing to deliver HIV programmes in the remaining districts. The 27 high-burden districts account for 82% of all people living with HIV and the majority of new infections (2). However, MMC services cannot be denied to men in lower-priority districts, and so a balance needs to be found between prioritising high-burden areas and ensuring a core package of services to all men wherever they live.

The demand-generation strategy naturally follows the overall national MMC guidelines in terms of the delivery of services to high-burden and lower-burden districts, respectively. While this has yet to be finalised, it is anticipated that in the lower-burden areas MMC will be integrated as far as possible into routine delivery of PHC services.

Table 4: Potential approach to MMC in high priority and lower priority areas

	High-priority districts and areas	Lower-priority districts and areas
Target setting	NDoH to set ambitious targets: 80% of uncircumcised men in the geographic area	NDoH to set less ambitious targets, based on capacity of service providers
Identifying men	Active identification of areas with concentrations of uncircumcised men and men who are at high risk for HIV infection. This may include places of work as well as secondary schools and higher education institutions	Provision of MMC services are situated in areas of higher population density. Focus will be on sustaining MMC prevalence and targeting secondary schools and higher education institutions
Delivering services	A combination of fixed sites, outreach services and mobile services to ensure that as many uncircumcised men are reached as possible	Equipping an adequate number of fixed health facilities with MMC services. Possible provision of mobile or outreach services to more remote communities
Demand generation	A comprehensive approach, saturating areas with demand-generation activities. Social mobilisers are appointed specifically to recruit men for MMC. There is a focus on local media and outreach activities	Demand generation for MMC will leverage off national campaigns and be integrated into general PHC approaches. Social mobilisation for MMC becomes the responsibility of the PHC ward-based outreach teams

4.2.2. Critical mass

Demand generation is most likely to have major impact where there is a critical mass – or large population – of men who are potentially interested in health-related messaging. Note that the list below is not exhaustive but provides some examples of settings that are likely to offer critical mass. There may be additional settings and/or groups who share similar characteristics to these groups which also makes them a good target for MMC demand-generation activities.

4.2.2.1. Educational institutions

Younger men within the priority age spectrum may be located in high schools (where learners are typically aged between 15 and 18 years) and higher education institutions (HEI). At this age, men are often concerned about fitting into their peer group – a factor that may contribute towards the social normalization of MMC.

The national HEAIDS programme coordinates HIV prevention and care at all universities and TVET colleges and many institutions have HIV programmes and on-campus health facilities, as well as campus radio stations that participate in health promotion. This is also a group which may be engaged with social media platforms. These resources could be leveraged for MMC demand generation.

4.2.2.2. Correctional Facilities

The population of men in correctional facilities fits the MMC target well in terms of age and risk of HIV infection, and absence from work seldom constitutes a barrier. Some correctional facilities have peer leaders who educate other inmates on health matters and have served as peer mobilisers for MMC. Like any mobiliser, they require the right tools and training as well as IEC materials in order to mobilise for MMC effectively.

Some MMC implementing partners have established working relationships with the Department of Correctional Services (DCS) and have access to men in correctional facilities. The NDoH seeks to strengthen its relationship with the DCS in order to centralise these partnerships and build a comprehensive men's health programme for inmates. It is crucial to get the buy-in of health personnel at correctional facilities especially since they will provide post-operative follow-up care.

4.2.2.3. Workplaces

The workforce in South Africa predominately, in both formal and informal labour industries, comprises of male employees. In addition, the workplace is where most men spend the majority of their day. There are two aspects to generating demand at the workplace: convincing the employer and only then approaching the employee. To be effective, it is necessary to articulate the benefit upside for both parties.

Employers want a healthy workforce in order to maximise productivity. MMC can be a hard sell as it involves taking healthy men away from work for an elective surgery. However, the advantage of supporting MMC in the workplace for employers and companies at large is that a healthy workforce promotes productivity, is cost-saving in the long term in terms of harm reduction, time off for clinic visits and access to antiretroviral therapy (ART). In addition, by supporting MMC, employers are promoting their credibility as socially responsible and proactive within their communities.

The South African Government is one of the largest employers in the country and government departments and institutions should be advocates for medical circumcision of male employees as part of a comprehensive health package for employees.

4.2.2.4. Mines

Mines are male-dominated workplaces, which makes them a good environment for MMC recruitment. Mines also tend to provide medical services to their workers and on-site facilities can reduce the need

for workers to seek medical care elsewhere. The most likely barrier faced by mineworkers (and their employers) is the time required for healing after MMC and the potential for post-operative infection for subterranean miners.

4.2.2.5. The military

The Department of Defence (DoD) is one of the largest employers of men in SA and members of the military are at high risk of HIV infection. The various military services, which have their own HIV programmes, would be important arenas for MMC recruitment. In order to gain access to the military, it is important for MMC providers to establish a working relationship with DoD.

4.2.2.6. Religious institutions

Some religious communities are open to presenting public health messaging in their places of worship. It is critical to obtain the support of the religious leader at the local institution. Permission at a regional or national level may be required prior to making the approach at local level.

4.2.2.1. Sporting events and entertainment venues

Sporting events, such as community soccer games, are mostly attended by men especially men aged within the MMC target population. Sometimes media or marketing booths are set up and various promotional activities are conducted at these games. This provides an enabling platform by which MMC can be added to the promotional marketing campaigns. Mobilisers should obtain permission from the venue operator to set up a booth and/or to promote MMC.

4.3. WHO ARE THE INFLUENCERS?

While men are the primary audience in demand-generation activities for MMC, social influencers can have a critical impact on a man's decision to undergo MMC. These influencers include male peers, romantic partners, family members and individuals in the community (12).

Their support – or lack of support – can be a decisive factor in men's choice whether to circumcise (13). Demand-generation activities must therefore seek to enhance support for MMC among individuals who have the potential to influence men who are considering MMC (14).

4.3.1. Male peers

Peer group attitudes to and beliefs about MMC as well as the experiences of peers who have undergone medical circumcision can be a major influence on men's decision to circumcise (23). The social acceptability of MMC and positive pressure from within the peer group might encourage an individual to opt for MMC (14).

On the other hand, negative attitudes and beliefs, false perceptions and negative experiences of MMC among male peers can lead men who are part of the group to become anxious about MMC and discourage them from undergoing the procedure.

To create a supportive peer structure, it is important that mobilisers understand male social networks and relationships in different settings. The approach should include:

- Identifying prominent male social groups and directing mobilisation activities at these groups. These could include members of sports clubs and regular patrons of popular taverns.

- Men that are considered popular or role models within local settings serve as effective catalysts for behaviour change. These men should be identified at each setting and recruited to become a spokesperson for MMC.

- Attempting to understand and address myths and misconceptions about MMC that prevail in various social networks, including those relating to the procedure, post-operative healing and sexual performance after MMC.

- Providing men in various social settings with a realistic and relatable account of the procedure and healing process by encouraging circumcised men who are part of their networks to talk about their experiences.

- Allowing men to develop their own coping strategies through a consultative process with their peers who have undergone the procedure.

- Ensuring that health workers provide good service during the procedure and follow-up care, so that men recommend MMC services and relay positive experiences to their peers.

- Recruiting men who have undergone MMC and are members of important male networks as social mobilisers who work within their communities.

4.3.2. Women

Mixed views exist on whether women's views on MMC have a significant impact on uptake of MMC by men and/or boys. In some instances women have been considered an important audience for MMC communication messages (24) where women have been able to leverage the expected sexual benefits are key enablers for young men, and concern for long-term partners' health are a key enabler for older men to encourage men to circumcise. However, women may also be detractors of MMC in some situations where men may find women putting negative pressure on them.

Given that women often have a vested interest in the health of their sons and romantic partners, it is imperative to include women in demand-generation modalities. However, care should be exercised in terms of the demand-generation approach due to the existence of cultural nuances prevalent in South Africa where women may not necessarily be able to speak forthrightly about male sexual practices and male sexual health. Therefore, those generating demand should understand the relationships between men and women in different contexts before actively involving women in the process of men making decisions on MMC. It is important to:

- Understand male perceptions of women and their ability to communicate and engage men on MMC in different contexts and within different cultural practices.

- Understand the preferences of men in different social settings in terms of the gender of MMC social mobilisers.

- Ensure that men understand the health benefits of MMC for themselves, their partners and their families.

- Ensure that women have sufficient knowledge about MMC to be able to support and comfort their partners or sons during and after the procedure, when needed.

4.3.2.1. Romantic partners

Women in their role as romantic partners may play a critical part in encouraging MMC. Women who understand the benefits of MMC for themselves and their partners have shown a preference for having sex with men who are circumcised (25). These perceptions about the sexual desirability of circumcised men can have a positive influence on men's decisions to get circumcised.

Women can provide significant support and post-procedure care for their partners. This would help men to adhere to the requirements of post-operative care, including sexual abstention for six weeks to enable the wound to heal (24). Lack of partner support can be a barrier to MMC for men contemplating medical circumcision (13). In order to offer support, women must be well informed about the health benefits of MMC and the nature of the procedure and recovery process.

4.3.2.2. Mothers

Women in their capacity as mothers and guardians can either encourage or discourage the medical circumcision of their sons (25). It is vital that demand-generation activities strive to create positive attitudes to MMC among the parents of male children. Where MMC is acceptable to her son, a mother can support his decision and provide formal consent for MMC (26).

Generating support for MMC among mothers of boys entails providing them with sufficient information about the procedure and its benefits for their sons. This includes ensuring that parents of male children understand:

- The higher risk of HIV infection and STIs among male children who are uncircumcised and sexually active.
- MMC improves penile hygiene.
- How to care for their sons after surgery, including holding discussions with them about sexual abstinence to enable healing (27).

4.3.3. Traditional, religious and hostel leaders

Traditional and religious leaders are highly respected in some communities and exert an influence on individual and community beliefs and behaviours. In some circumstances, traditional and religious beliefs about circumcision that are held and reinforced by these leaders can be a major barrier to the acceptance of MMC by members of the community. Engagement with and education of traditional and religious leaders can have a substantial effect on the uptake of MMC (28).

Religious and traditional leaders

Demand-generation activities for MMC should involve religious and traditional leaders especially in contexts where male circumcision is imbued with cultural and/or religious significance. In such contexts, an effort should be made to include religious and traditional leaders as champions of MMC to increase uptake.

To achieve this, it is important to:

- Establish a relationship of trust between healthcare providers and traditional/religious authorities through open communication and ongoing engagement about MMC.
- Promote understanding that MMC does not seek to replace or compete with traditional practices, but rather augment the process by ensuring optimal health of the initiates.

- Ensure that leaders understand the MMC process and the medical benefits in comparison to traditional circumcision, including post-operative wound care and need to practise safe sex after circumcision.
- Explore with traditional leaders the possibility of collaboration so that men can undergo medical circumcision but still participate in traditional rites of passage to manhood.
- Educate leaders about the health benefits of MMC for men and women.
- Encourage leaders to champion MMC activities in their communities.
- Provide the necessary support and materials for leaders to educate their constituencies or congregations about MMC.

Hostel leaders

Male-dominated industries, such as mining, often have hostels that accommodate large numbers of male workers in the priority age range for MMC. In many instances, hostels have a leader or group of leaders responsible for overseeing the hostel and addressing matters of concern to the residents. The men who are selected for these positions are often perceived as influential and capable of leading other men. Demand-generation activities should aim to engage these men in relation to MMC and work with them to gain access to large numbers of residents.

4.3.4. Healthcare workers

Like other influencers, healthcare workers can be detractors or motivators for MMC. It is important that all healthcare workers are aware of MMC and its benefits and capable of encouraging uncircumcised men to become circumcised. For MMC to be a sustainable programme and meet its goals, it must be seen as part of a comprehensive sexual reproductive health package for men.

In healthcare settings, there are many linkages to MMC and from MMC to other PHC services. The HTS programme has particularly strong links, as all men who test HIV-negative should be actively linked to MMC services.

Men tend not to utilise public health facilities and MMC may be their first experience of the health services. If this is a positive experience, the individual may be more likely to seek other services. MMC can be an important gateway to better health for men.

However, a healthcare worker can reduce the impact of the MMC programme if he or she fails to see the programme as part of a comprehensive sexual reproductive health package and persists in regarding it as a standalone service. It is important for MMC coordinators to work to bridge any gaps with other health programmes in order to reap mutual benefits.

4.4. SUMMING UP

Section 4 should assist implementers with planning their activities in terms of where they should focus their efforts to maximise the number of men who undertake to protect their health through MMC. It provides guidance on how to approach the relevant institutions or settings that offer access to large numbers of men in the target age range. It also provides insights on the usefulness of including gatekeepers or influencers as secondary audiences and suggests how to do this.

In section 5 we move from the “who” and “where” of MMC demand generation to the question of “what” we say to key audiences – in other words, the complex question of messaging.

5. TAILORING THE MESSAGE

Demand-generation messages must resonate with the man we hope to persuade to opt for MMC. The theory of change presented in section 3 highlighted the ideational factors – knowledge, beliefs, attitudes and social pressures – that can serve as barriers to behaviour change and factors that may enable individuals to overcome ideational barriers. The theory also stresses the existence of structural barriers to behaviour change that cannot be overcome by communication alone.

The importance of understanding barriers and enablers is emphasised by a study (13) that found that there were generally sufficient MMC services in South Africa and that men had adequate knowledge of MMC – with many expressing an intention to circumcise – but a large proportion remained uncircumcised.

This section begins by examining ideational barriers and enablers as a factor in message development and then proceeds to explore the stages of decision making as another key factor to consider when framing messages.

5.1. IDEATIONAL BARRIERS AND ENABLERS

Lack of knowledge of MMC benefits

About half of South African men and women aged 16-55 years know that MMC reduces the risk of acquiring HIV (48%) and other STIs (54%). This implies that about half of the men who are approached by mobilisers are unlikely to understand this protective benefit and this a substantial ideational barrier to MMC. An enabling response would focus on addressing the lack of knowledge and focusing on their sexual health.

Low perception of relevance of MMC's benefits

Some men know the benefits of MMC but do not consider these relevant to their circumstances. For example, they may believe that they are not at risk of becoming infected with HIV. This is a significant barrier because it indicates that the men concerned have not even begun to consider MMC (29). Enablers might include a focus on the benefits to the man's partner, the preference of many women for medically circumcised men, and cultural norms that support MMC.

Avoidance of HIV testing

Research has found that a strong deterrent among men who would like to get circumcised is anxiety about getting tested for HIV as part of the process (30). Men do not test for HIV as routinely as women and many fear finding out their HIV status. Enablers could include accessing information that HIV testing is not compulsory for MMC and that access to ART is immediate for those who test positive, as well as promoting that knowing one's status enables one to make informed health decisions.

Anticipated pain

A number of studies have found that anticipation of pain prevents men who intend to get circumcised from going through with the procedure (30-33). Most men considering MMC have no experience of a similar procedure and are likely to expect severe pain. Social mobilisers tend to dismiss fears relating to pain. Men who have been circumcised have usually forgotten the pain, while men contemplating getting circumcised are likely to overestimate the pain. So there is a disconnect in pain perception between potential clients and those advocating MMC – and this can cause distrust (29). Men also fear

managing erections and believe that the pain level is the same throughout the six-week healing period. Enabling actions could include facilitating a discussion with a medically circumcised man who is trusted, acknowledging that some pain is likely but transient and restating the sexual benefits of MMC.

Anticipated shame

Men have indicated that they would feel shame if they met people they know at the clinic, when exposing themselves to strangers, especially female doctors and nurses, and if they had to walk or dress unusually immediately after the procedure. Older men also feel shame when waiting in the same room as young boys who are also being circumcised. Enablers might include communicating the experience and professionalism of staff regardless of gender.

Anticipated loss

There are three kinds of loss men associate with MMC: loss of sex during the recovery period, an anticipated reduction in sexual pleasure, and a loss of alignment with one's cultural or religious group in cases where these groups do not circumcise. Enabling discussions should focus on the early benefits of MMC, the new kinds of sexual pleasure MMC brings, and the fact the MMC for health reasons has long been accepted by many groups who do not traditionally circumcise.

Uncertainty

Even men who would like to circumcise and have a good understanding of the benefits of MMC, may feel anxiety and uncertainty about the procedure itself. Men in South Africa often have low levels of exposure to the healthcare system and, since MMC is a once-off event, cannot imagine what it entails. Provision of clear information about the procedure and after-care, and referral to a trusted service provider and/or trained peer advocates who are circumcised are both relevant enablers.

Distrust

Two main issues relating to distrust have emerged from the literature. Firstly, where women have been used to promote MMC to their sexual partners, there is often distrust of their motives for doing so. Men may feel that they carry the risks of MMC, while their partners enjoy the benefits. Secondly, distrust may emerge when men who have been circumcised under-represent the pain involved.

5.2. STRUCTURAL BARRIERS AND ENABLERS

Anticipated financial loss

Men intending to circumcise often anticipate financial losses due to absence from work and transport costs. Clinics and MMC service centres are not always easily accessible, especially in rural areas. If clients cannot reach the clinics they will forego the procedure (13). Enablers would include facilities operating outside normal working hours, using mobile clinics, contracting general practitioners, assistance with transport costs and emphasising that the procedure is free.

Clinic factors

Men perceive clinics to lack privacy and find their opening hours difficult (30, 34). The lack of male-friendly clinics with trained male staff to perform MMC procedures is an important structural barrier for MMC (35).

Older men are often uncomfortable waiting in the same room as younger boys (13) and the lack of separate waiting and service areas for men and boys can discourage older men from seeking medical circumcision at clinics. An enabler could be allocating certain days of the week for older men only and documenting positive experiences at the clinic to share with others.

Timing of MMC

Seasonality of MMC in SA is highly conspicuous and it is thought to be primarily based on:

- Misconceptions about wounds healing slower in summer than winter
- The historical practice of traditional circumcision in winter
- School holiday periods where large numbers of boys seek MMC

There is substantial resistance to MMC in the warmer months. Some adolescents and young men are also reluctant to get circumcised during sports seasons and exam periods (32). Demand-generation activities need to address these barriers by aiming to schedule school-going boys for MMC during weekends and public holidays and correcting misconceptions about the weather affecting the healing process.

5.3. STAGES OF CHANGE, BARRIERS AND ENABLING ACTIONS

Messaging is also developed to suit men at different stages in the process of deciding to undergo MMC. This strategy utilises the Stages of Change Model to chart the journey to MMC. The model assumes that people do not change their behaviours quickly and decisively but instead move through defined stages to new behaviour, as indicated in Figure 5 (29).

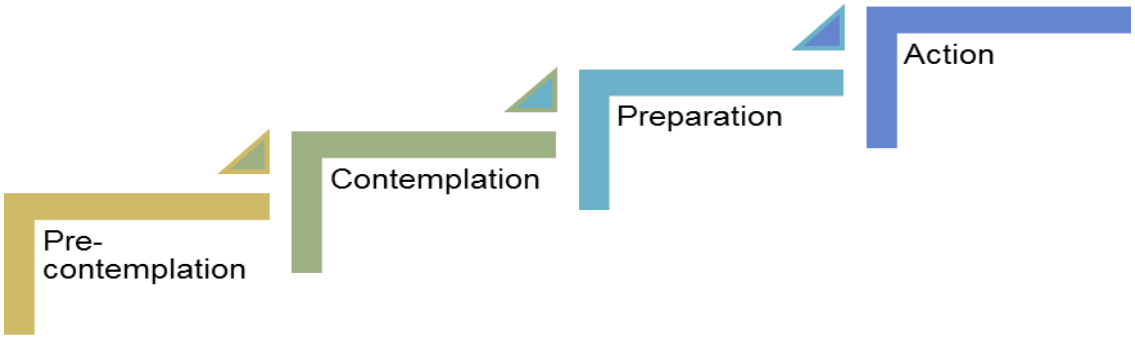


Figure 5: Stages of change model applied to MMC

These stages are elaborated on in Table 5 and linked both to specific barriers and relevant enabling actions.

Table 5: Stages of Change model applied to MMC

Stage	Definition	Application to MMC	Barriers and enabling interventions
Pre-contemplation	No intention to take action in next six months Lack of awareness	The individual is unaware that accessing MMC is potentially	Lack of knowledge of benefits of MMC Low perception of personal

Stage	Definition	Application to MMC	Barriers and enabling interventions
	of innovation that can benefit health and hygiene Underestimation of pros of changing behaviour and excessive emphasis on the cons	beneficial to his health and his sexual relationship(s)	relevance of benefits of MMC Communicators need to: 1. Understand men's health needs 2. Increase knowledge of MMC 3. Reframe overall sexual health benefits that are relevant to particular groups of men
Contemplation	Intention to initiate action for health in next six months. Recognition that current behaviour may be detrimental More thoughtful, practical and balanced consideration of pros and cons of changing the behaviour. But ambivalence to change may linger	The individual begins to recognise that accessing MMC may protect his health and even benefit his intimate relationships. He may begin to use MMC information materials	Avoidance, anticipated pain, shame and loss, and uncertainty Communicators need to: 1. Acknowledge pain and address specific concerns plus provide examples of procedures with comparable level of pain 2. Encourage pride in taking responsible action 3. Highlight strong trend toward MMC 4. Remind individual of immediate benefits of MMC: cleaner penis, fewer STIs and better sexual performance 5. Involve leaders of religious and cultural communities where circumcision is not the norm to reduce sense of exclusion 6. Discuss details of procedure and after-care well ahead of admission
Preparation (Determination)	Ready to take action within next 30 days. Small steps taken towards behaviour change in belief that action can lead to a healthier life	Individual enquires about MMC and makes an appointment through a social mobiliser or call centre	Anticipated loss of income and distrust Service providers may enable progress by providing vouchers for MMC (see guidance below) and employers can grant paid "sick" leave

Stage	Definition	Application to MMC	Barriers and enabling interventions
			Communicators need to: 1. Raise awareness of above benefits, where available 2. Facilitate discussion with peers who have undergone MMC
Action	Behaviour change achieved within last six months. Intention to keep moving forward with change. Possible introduction of additional healthy practices	The individual accesses MMC	Clinic-related barriers: lack of privacy and inconvenient hours of operation plus anticipated shame during and after procedure Communicators need to provide accurate information on clinic hours and share numbers to show how normal MMC is becoming
Maintenance	Behaviour change sustained for more than six months with intention to continue to maintain new behaviour. Effort made to prevent relapse to earlier practices	The individual maintains ongoing HIV risk-reduction behaviour, such as condom use	Doubt as to relevance or benefit of post-operative care and continued HIV risk-reduction measures Communicators need to explain importance of both

Box 1: Guidance for cost reimbursement

Occasionally promotional campaigns use incentives to persuade men older than 18 years to opt-in to MMC. This may assist in attaining ambitious targets within a short period of time. While cash transfers to clients are forbidden, it is possible to offer food vouchers or transportation refunds to compensate individuals who choose to undergo MMC. Short-term campaigns offering incentives of this nature must be clearly identified as time-limited in order to avoid creating expectations of ongoing cost reimbursements. Budgets for MMC are often limited and therefore cost reimbursement is not a sustainable solution for demand generation and cannot replace the use of other enabling methods.

5.4. MATRIX FOR TAILORING MMC MESSAGES

The matrix in Table 6 presents messaging suited to each stage of change and calculated to address common barriers to change. In creating this matrix, the “Experience Framework” developed by Upstream, Final Mile and IPSOS Healthcare in collaboration with the Ministries of Health and Zambia and Zimbabwe (29) has been drawn on.

Table 6: Matrix to be used to tailor MMC messages

Stage	Barrier	Type	Description	Messages	Channels	Influencers
Pre-contemplation	Lack of knowledge of benefits of MMC	Ideational	Low knowledge of benefit of MMC	MMC reduces the risk of HIV infection in men by about 60%	Mass media	Celebrity endorsement
	Low perception of relevance of benefits of MMC	Ideational	Men do not believe that they are at risk of HIV infection and therefore MMC has no relevance to them	MMC has multiple short-term benefits like protection from STIs and better hygiene Any sexually active man, regardless of relationship status, is at risk of STIs Roughly half of all men in South Africa are circumcised	Mass media targeted at men who will find specific benefits relevant. Use respected figures as spokespeople and testimonials of recently circumcised men Interpersonal communication with Q and A tools to determine individual's awareness of benefits and which are relevant	Medically circumcised men: talk about the multiple short-term benefits, such as a clean penis and reduced STIs Family: speak about the benefits of man's health to the larger family Friends: invoke a sense of community norms and that MMC has multiple benefits Healthcare workers: communicate relevant benefits according to men's individual situations
		Ideational	MMC is not relevant in context of current relationship (for example, when married to partner)			

Stage	Barrier	Type	Description	Messages	Channels	Influencers
Contemplation	Avoidance of HIV testing	Ideational	Anxiety about getting tested for HIV	HIV testing is encouraged but it is not mandatory to be tested before MMC	Interpersonal communication	Family and peers: provide a supportive environment for an individual regardless of test result
	Anticipated pain	Ideational	Anticipated pain of procedure	MMC is done under anaesthetic so there is no pain during the surgery but there is pain for a short time while you get the anaesthetic and afterwards, while the wound heals Additional information should include: Comparisons: "It is as painful as . . ." Pre- and post-estimates of MMC pain: "I thought it would be 9/10 but was 4/10" Address specific pain issues, for example injections. Explain that there is only one injection at the base of the penis and that it is given by an expert Provide coping strategies: drinking cold water or using ice to deal with erection-related pain, and taking painkillers	Testimonials Interpersonal communication	Medically circumcised men: testimonials on overestimation of pain Friends: suggest shared activity to help overcome pain post-procedure Healthcare workers: honest conversation about pain. Use testimonials relevant comparisons to help describe pain Participation of traditional leaders especially in communities that practice traditional circumcision
	Anticipated shame	Ideational	Anticipated shame	MMC has benefits to the wider community. Circumcised men are those who care for their communities Roughly half of all men in South Africa are circumcised	Interpersonal communication	Romantic partner and peers: never too late to do the right thing. Set a good example for children/family

Stage	Barrier	Type	Description	Messages	Channels	Influencers
	Anticipated loss	Ideational	Anticipated loss of religious/cultural alignment (where most men in group are not circumcised)	MMC for health reasons has long been done by men from groups who do not circumcise for religious or traditional reasons. This has become more important with the rise of HIV in our communities MMC in our current situation is an act of responsibility towards your partner, your family and your community	Interpersonal communication	Family can support individual with acceptance and understanding Traditional leaders can communicate that medical circumcised men still belong with community Healthcare workers who can emphasise the risks averted and benefits to family Other men from the group who have undergone MMC and can speak of personal benefits
		Ideational	Anticipated loss of sexual pleasure due to anticipation of reduced sensitivity	Framing loss of sensitivity positively. Benefits of reduced sensitivity are: - Women's appreciation of more attractive partner (cleaner, healthier) - Perception that a medically circumcised man cares for others	Interpersonal communication	Medically circumcised men: talk about improved sexual performance in one-on-one settings Romantic partner: may have preference for circumcised penis (hygiene, sensation) Healthcare workers: address anticipated loss of sensitivity by communicating aspects of sexual performance that improve with MMC
		Ideational	Anticipated immediate loss	MMC has multiple short-term benefits like protection from STIs, better hygiene and	Interpersonal communication	Romantic partner: reassure and comfort partner during the six-week

Stage	Barrier	Type	Description	Messages	Channels	Influencers
			of sex due to abstinence for six weeks	improved sexual performance Suggest methods to alleviate pain of erection		abstention period
	Uncertainty	Ideational	Uncertainty about procedure and timelines	Precise explanation of the various steps, using localised information Answer Frequently Asked Questions (FAQs) about the procedure Give precise information about how long each step should take, for example: anaesthesia = 5 minutes	Mass media with for high-level information on procedure and the infrequent risks associated with MMC Interpersonal communication to describe and discuss the various steps and timelines in detail	Healthcare workers: can explain the procedure in detail and with authority Medically circumcised men: can relate their experiences
		Ideational	Uncertainty of implications of procedure, for example, anticipation of reduced sensitivity	Loss of sensation is not total and there are other aspects of sexual pleasure that increase with MMC		
		Ideational	Uncertainty about surgical complications (bleeding and wound healing)	Present up-to-date and local information regarding adverse events Use data/norms to show that complications are rare and not life-threatening Communicate coping strategies: “Proper wound care is easily done by many men”	Interpersonal communication from a trusted source	Medically circumcised men: can discuss their healing period and (good) surgical experience Healthcare worker: can discuss the realities of procedure and healing period

Stage	Barrier	Type	Description	Messages	Channels	Influencers
Preparation	Anticipated loss	Structural	Financial loss. Loss of wages due to leave taken for the procedure and recovery and cost of transport	Support messaging about provision of vouchers or time off where this exists Communicate exactly how many days men will need to be away from work as men may overestimate loss of wages	Mass media useful for communicating any policy level interventions dealing with financial loss Testimonials by community members on how they coped with financial loss Commitment devices	Testimonials by medically circumcised men on how they prepared for and coped with financial loss Friends can talk about personal experience how they coped with loss of wages to help men develop their own coping strategies Healthcare workers can communicate any policy intervention
	Distrust	Ideational	Distrust between sexual partners: why do you want me to get MMC?	Reduce focus on partner-driven messaging Focus on mutual benefits, such as. hygiene and better sexual performance	Interpersonal communication	Male peers
		Ideational	Distrust of representation of pain by circumcised men	Talk about own pain and overestimation of pain (in the case of a circumcised peer mobiliser) Address specific pain concerns of individual rather than pain in general Provide reference points for pain: “As painful as . . .	Mass media can communicate the fact that men tend to overestimate pain but at the time deal well with it Interpersonal communication	Medically circumcised men talk about overestimation of pain

Stage	Barrier	Type	Description	Messages	Channels	Influencers
Action	Clinic factors	Structural	Lack of privacy and opening hours	Where these exist, discuss the measures taken to ensure privacy for older men (separate waiting rooms) or more convenient times (evenings, weekends, mobile clinics) Ensure information about clinic availability is accurate	Radio is localised and can talk about specific clinics in the area in detail	Healthcare workers: inform men when clinics are open and what the waiting room situation is like (for example, when children are more likely to be present)
	Anticipated shame	Ideational	Anticipated shame at time of service	Share information about MMC becoming a social norm: "Last year, XXX number of men from your district got circumcised"	Interpersonal communication Use of social media as a platform for discussion among newly circumcised men	Medically circumcised men can be leveraged to create a social group where MMC is the norm and communicate how they managed shame Friends are the biggest influencers, so encourage men to talk to more friends who have been circumcised Healthcare workers can be effective in providing coping strategies
		Ideational	Anticipated shame while healing	Provide coping strategies, such as avoiding trigger events during healing period Encourage men to seek out other circumcised men as friends		

Stage	Barrier	Type	Description	Messages	Channels	Influencers
Maintenance	Low perception of relevance	Ideational	Lack of perceived relevance of follow-up visits	Men who have been circumcised need to go for follow-up at 48 hours, 7 days and 14 days in order to guard against complications	Interpersonal communication Post-op IEC material	Healthcare workers: need to reinforce importance of proper wound healing
		Ideational	Reluctance to continue use of condoms when circumcised	All men need to continue to use a condom every time they have sex	Interpersonal communication	Romantic partner: remind partner about preventing unplanned pregnancies and added protection against STIs

6. COMMUNICATION METHODS

This section discusses various communication methods that can be used to convey messages both to the primary audience of men in the priority age range and to a wider secondary audience of influencers. Ideally two or more methods should be combined in an integrated manner to achieve greater impact.

The options include:

- Interpersonal communication, is an exchange of information between at least two individuals; it includes the work undertaken by social mobilisers and call centre staff.
- Use of the mass media, which includes television, radio, print media and online publications ranging from major national media, through regional media that reach particular provinces or metro areas, and community media.
- Use of digital and social media, ranging from traditional websites to the use of platforms like Facebook, Twitter, Instagram and YouTube.
- Development and dissemination of small media or materials, which are produced as tools to support interpersonal communication whether this takes place in the community, the workplace or the health facility.
- Advocacy which combines several of the above methods with the specific objective of influencing people in authority to change a policy or a cultural tradition.

Figure 6: Major elements of integrated communication

6.1. SELECTION OF COMMUNICATION METHODS/ CHANNELS

Communication channels have different characteristics – which are discussed in this section – and they are generally combined in order to make the strongest possible impact on the audience. The selection of channels for particular purposes is guided by:

- Knowledge of the audience:
    - What media are they likely to consume?
    - What stage have they reached in the decision-making process and what channels best match that phase?
    - What kinds of barriers are they facing and are these best addressed face-to-face or through mass media?

- The information to be conveyed:
    - Does the situation require detailed information to build knowledge or powerful short messages to build confidence and normalise MMC?
    - Will men be able to recall the information if it is delivered only by mouth – or is written back up necessary?
    - Is once-off exposure to the information sufficient or do messages require numerous exposures?

The range of communication channels used at any time will fluctuate. Generally, it is too expensive to involve the mass media continuously and these channels are reserved for special campaigns to boost the response, focus on new messaging or take the service into new geographic areas.

6.2. COMMUNICATION PLANNING

In order to deploy the various channels in an organised manner, it is necessary to develop an implementation plan that specifies the sequence and frequency of interventions, the audience they expect to reach, the messages to be conveyed, and those responsible for implementation and the required resources.

Communication planning needs to be an integrated activity at national, provincial, district and local level. This is because the planning of national and regional mass media activities will probably rest with the NDoH, the Phila initiative and provincial health departments, while the use of community media and fine-tuning of inter-personal communication will rest with districts and individual MMC facilities.

This strategy recommends the use of the P-Process, developed by the John Hopkins Bloomberg School of Public Health, which adapts basic management practice for application in the planning, implementation and M&E of communication interventions. It comprises five steps and is underpinned by two guiding principles: participation and capacity strengthening. It is suggested that communicators apply this approach in developing and implementing MMC communication plans.

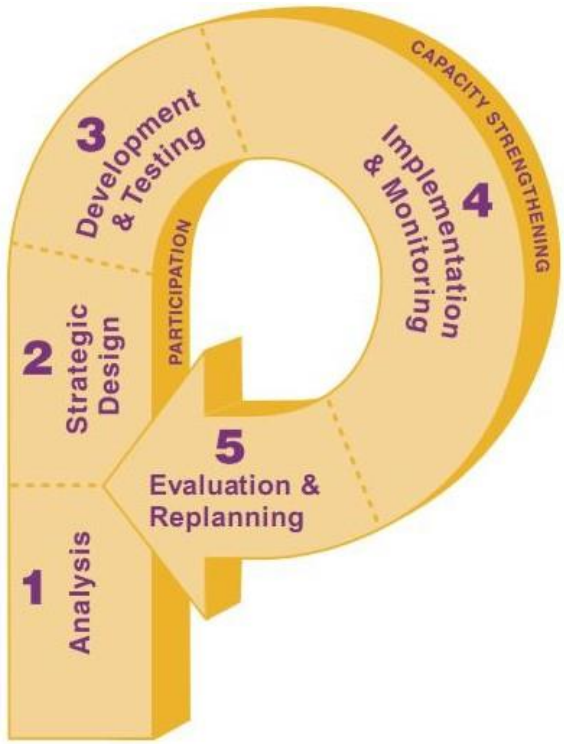


Figure 7: P-Process for communication planning

Step 1: Analysis

Planners and implementers should undertake primary and secondary research to ensure that each MMC campaign is evidence-informed and locally appropriate. Formative research can help ensure that each campaign effectively addresses the needs of the men it aims to reach. This should explore social, cultural and economic factors that inhibit or enable men to access MMC in the targeted geographic area. Because considerable research has already been integrated into this strategy, formative research for implementation can take the form of a rapid, local assessment.

Step 2: Strategic design

Implementers should use the analysis to prepare a communication implementation plan that sets out the campaign objectives and outlines the key audiences for specific demand-generation activities. The plan should outline the strategic approach to reaching the targeted audience(s) and the assumptions behind this approach. It should also identify key themes and MMC messages in line with this strategy's guidance on tailoring the message. Finally, the document should indicate demand-generation activities and communication channels that are suited for specific target audiences. The strategic document can be shared with local stakeholders to enable their active participation in the process.

Step 3: Development and testing

Based on the communication plan, implementers can develop materials such as radio scripts or pamphlets featuring the messages that have been selected. If it is possible to involve some representatives of your target audience in materials development, this is encouraged as it can help ensure audience needs are met. Draft materials should be tested – by getting a sample of your intended audience to review and comment on the draft text and illustrations – and then refined.

Step 4: Implementation and monitoring

Implementation of demand-generation campaigns at a local level need to be continuously monitored in line with relevant provisions of the M&E section of this strategy.

Step 5: Evaluation and re-planning

The M&E findings should be used to review your communication plan and revise approaches, channel selection or messages that were ineffective in reaching the priority audience(s) or not well received by the audience(s). The improved plan should guide implementation going forward.

6.3. INTERPERSONAL COMMUNICATION

Interpersonal communication (IPC) is an exchange of information between at least two individuals. In MMC demand generation, interpersonal communication allows for very targeted communication and for individualised messaging. This sets it apart from most other forms of communication, where messages are standardised and remain static. Effective IPC requires well-selected and well-trained people to deliver the messages appropriately. It is more difficult to monitor the quality of IPC because the method is highly individualised but guidance is provided in section 7.

6.3.1. Social mobilisation

Social mobilisation is one of the primary forms of IPC for generating demand for MMC. It is a planned but decentralised process. It brings together a wide range of parties with a shared interest in order to raise awareness of issues through dialogue and create pressure in support of a development objective. Social mobilisation is essential to demand generation for MMC. Mobilisers – who often include medically circumcised men – convey messages directly to people in their preferred languages, answer their questions, link them to services, and distribute IEC materials. They are able to address specific concerns of individuals in a unique way.

6.3.1.1. Recruitment of social mobilisers

Proper recruitment of social mobilisers is crucial to the effectiveness of this form of communication. When selecting social mobilisers, the following should be considered:

- Social mobilisers should have knowledge of HIV, STIs and tuberculosis (TB) and it is advantageous if they understand the methods of health promotion or social marketing.
- The MMC follow-up process could be used to identify and later recruit recently circumcised HIV-negative men who might be suitable as peer mobilisers.
- Men living with HIV, who are comfortable sharing their status, could help other men overcome their testing fears.
- They should ideally be a peer, meaning someone who shares the culture, speaks the language of, is of a similar age (15-34) and living in the same area of the men they are trying to recruit. Older men respond better to men their own age.

Women should be appointed as MMC mobilisers on a case-by-case basis, if they have previous social marketing experience and they are trusted by the community. While some South African communities are not open to women speaking to men about sexual health; the reality is that most community health workers (CHW) and community caregivers (CCG) are female and constitute a major social mobilisation resource in many communities.

6.3.1.2. Training of social mobilisers

Social mobilisers should undergo standardised training which focuses on an evidence-informed approach to understanding MMC as a HIV prevention modality, the risks and benefits of the procedure, the barriers to MMC, and appropriate responses to these.

All social mobilisers should undergo similar training to ensure the consistency of factual information delivered to clients and the application of best practice. To ensure that training is manageable, it is recommended that social mobilisers be trained in groups of 20-25 people at a time. The training of social mobilisers for demand generation can occur at venues supplied by the NDoH. The venues normally come at no cost.

Social mobilisers should develop the confidence to modify standard techniques to suit their local context. Training should be based on best practices for mobilising clients and incorporate local experience in relaying complex concepts, such as biomedical prevention. As mobilisers are often the first point of contact with potential clients, they must be equipped to answer any MMC-related questions raised. This is particularly important in converting the individual's intention to undergo MMC into a definite appointment which is kept.

For best practices in training social mobilisers, refer to the *National Social Mobilisation Training Manual*.

The training should cover:

- Information about HIV, STIs, condoms and general concerns regarding men's sexual health.
- The risks and benefits of MMC and how MMC is part of comprehensive package of sexual and reproductive health services.
- Difference between traditional and medical circumcision.
- Identifying segments of the target population and adjusting approaches to meet specific needs.
- The prevention modality of MMC. How does MMC mitigate HIV infection?
- An overview of what the procedure entails.
- Post-operative requirements: an overview of wound care and abstinence.
- Available MMC services in the relevant area.
- Techniques on how to "close the gap" between intention to circumcise, and making and keeping an appointment.
- Methods for uncovering and addressing barriers to MMC, including fear of testing and pain.
- How to report on MMC demand-generation activities. Use of M&E tools developed for this purpose.

Experiential learning is an important part of training where new mobilisers have an opportunity for practical application of the theoretical knowledge learned. A probation or trial period should be included where new mobilisers would be observed in the field in order to identify and mitigate possible problems early.

Experiential learning is an important part of training to ensure that mobilisers have the practical skill to apply theoretical knowledge. A probation or trial period should be included during which new mobilisers are observed in the field. This helps to identify and mitigate possible problems early. Mentorship from seasoned and successful mobilisers can help coach and retain less experienced mobilisers by sharing locally-appropriate techniques.

There should be refresher trainings on an annual basis (as resources allow) to ensure that all mobilisers are provided with the most up-to-date information and aware of any programmatic changes.

Mobilisers also require materials for use in the field that facilitate conversations with men and women on sexual health and MMC. Mobilisers should be equipped with:

- A demand-generation toolkit consisting of a guide and IPC tools to aid the conduct of small group discussions and related interventions.
- IEC materials to give to individuals in the audience for them to keep and review. These materials should include a "please call me" phone number to enable men to get further information about MMC and support for making an appointment.
- Forms to collect the contact details of men interested in MMC and appointment cards to refer those who wish to make an appointment at a local clinic.
- Male condoms for distribution in order to reinforce consistent use both before and after MMC.

6.3.1.3. Remuneration

The contracting and remuneration of mobilisers will differ somewhat depending on whether they are working for non-governmental implementing partners or directly for a government department.

The same general principles should apply in both situations:

- The mobiliser may be employed on a fixed-term contract or as a permanent employee, but in either situation his or her responsibilities and conditions of service should be transparent.
- Rates of remuneration may vary within a range. Individual pay rates should be consistently determined in accordance with experience, skills, length of service and level of responsibility.
- The awarding of financial incentives, such as bonuses and merit increase, should be dependent on performance, available resources and established policies.
- Tenure positions should also be dependent on ability to perform, subject to the principles of fair labour practice – in terms of providing training, adequate support, and clarity about expected levels of performance.

6.3.1.4. Management

Management of social mobilisers is crucial and serves to support mobilisers, measure progress against targets, ensure quality service and troubleshoot problems. Managers should be responsible for monitoring and evaluating progress and developing an understanding of where and why mobilisation has been successful.

In the field, it is suggested to have one supervisor or team leader – an experienced mobiliser – to every eight mobilisers. The supervisor's role is to track daily performance, provide coaching and help resolve any issues experienced in the field. Being a supervisor is an opportunity for a mobiliser to grow.

Mobilisation should only be done when there are services to support. Therefore, it is important for mobilisers to know the availability of services in their area. Social mobilisers report to the supervisor who in turn reports to the facility manager. See section 8 for further reporting details.

Data should be used to monitor mobiliser performance. A successful mobiliser combines the ability to reach a high number of potential clients with quality communication that secures a good number of MMC appointments.

6.3.2. Call centres

A call centre comprises agents responsible for outbound and inbound calls who are backed by suitable software that provides on-screen prompts and standardised scripts to guide their interaction with potential MMC clients and measures the progress from initial contact to firm uptake of MMC

services. A call centre should be run at national level and requires up-to-date information about clinics across the country to best refer a man for services in his area.

Call centre agents provide a critical point of contact with men who are contemplating MMC. The key function of the call centres is to address the intention-action gap and convert men who have expressed an interest in MMC into clients who actually undergo medical circumcision.

Leads – potential clients identified by mobilisers, through a “please call me” message or through USSD code to find MMC sites – should be contacted through an outbound call by the call centre as the men concerned may not have airtime to contact the call centre. It is crucial that these potential clients receive personalised, scripted advice and are addressed in their preferred language.

Once men have made the decision to get circumcised, the call centre agent should book them for the procedure. To do so, the agent needs to know available MMC capacity in the area where the individual lives. In addition, the call centre can send SMS and telephonic reminders of the booking and possibly facilitate access to MMC transportation. It is crucial that call centres operate during the evenings and weekends in order to reach a wide range of men.

The call centre also plays a key role in the post-operative period, sending telephonic and SMS reminders of follow-up visits, promoting proper wound care, and helping client to identify and seek care for adverse events.

In order to ensure personalised use of standard scripting, call centre agents need to be thoroughly trained in using standardised tools and procedures.

6.3.2.1. Recruitment of call centre agents

Careful selection of call centre agents is crucial to the effectiveness of the service. The following characteristics should be considered:

- Call centre agents should have a sales or marketing background, while information on HIV and STIs can be written into the call script.
- Call centre agents should be multilingual or, alternatively, each call centre should ensure that its staff are collectively able to offer services in a wide range of local languages. Fluency in the prospective client’s language is critical in building rapport with him.
- Suitable men who have been circumcised could be ideal agents, as they can relate to the caller’s situation and use personal experience to reassure him.

6.3.2.2. Training of call centre agents

Call centre agents should also undergo standardised training, which focuses on the evidence-informed approach to understanding barriers to MMC, and the appropriate responses to these. A call-flow script should be developed which guides the agent through the conversation and is based on the responses from the caller. For best practise in call centre agent training refer to the *National Social Mobilisation Training Manual*.

The training should cover:

- Information on HIV, STIs, condoms and general concerns about men’s sexual health.
- The risks and benefits of MMC and how MMC is part of comprehensive package of sexual and reproductive health services.
- Difference between traditional and medical circumcision.
- How to build rapport with clients over the phone.

- Identifying segments of the target population and adjusting approaches to meet specific needs.
- Methods for uncovering and addressing barriers to MMC.
- The prevention modality of MMC – how it reduces HIV infection.
- An overview of what the procedure entails.
- Post-operative requirements: overview of wound care and importance of abstinence.
- Available MMC services in the area where they will be mobilising.
- Techniques on how to "close the gap" between intention to circumcise, and making and keeping an appointment.
- How to report on MMC demand-generation activities and use of M&E tools.

Call centres are expensive to run and require specific infrastructure to initiate. There are currently partner-run call centres in the country and there could be opportunities to link with existing national call centres such as the AIDS helpline and Lifeline to integrate with existing infrastructure for sustainability purposes.

6.3.3. Activations

An activation is a public event or series of events that aims to drive individuals to adopt a specific course of action through interaction and experiences. MMC activations are about bringing MMC to life via personal experiences and presenting relatable content to the target population.

Examples of activations are:

- Community sporting events which incorporate MMC promotion.
- Special events with celebrity endorsement.
- Health days in the community and/or workplace.

Activations should be a part of the wider demand-generation approach, and not standalone activities. As with all demand-generation activities, they must be adjusted to suit the local audience.

Activations require financial, human and IEC resources. They would generally be driven by social mobilisers – often in partnership with staff from other health organisations. It is important that the resources and budget are in place from the start in order to meet the desired objectives.

Activations for MMC may vary in nature. Some may aim to generate awareness of MMC, others to provide a fun environment in which it is possible to engage about MMC, and yet others may focus directly on offering an immediate MMC service at a mobile unit parked on-site.

Communicators should consider all options and determine the best fit for the target audience and the budget, and which tactic will deliver the best results in terms of current programme investments.

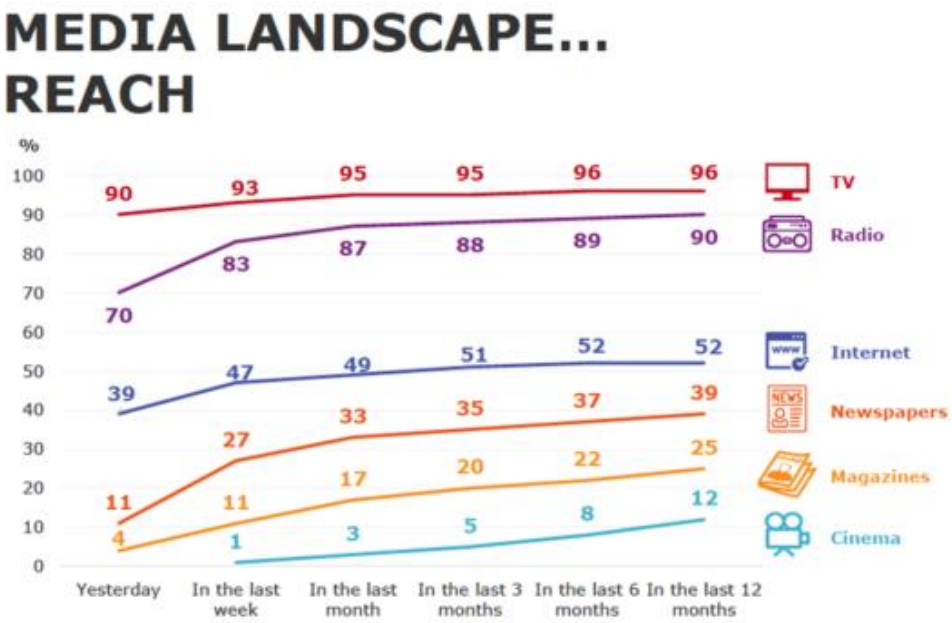
6.4. MASS MEDIA COMMUNICATION

The term mass media refers to communication channels that reach a wide audience – from thousands of people to hundreds of thousands – and are published on a regular daily, weekly or monthly basis. They are the primary means of communicating with the general public or broad interest groups – such as sports fans, young people, women or the business community.

Almost all South Africans consume some form of mass media – radio, television, newspapers, magazines and online publications – on a fairly regular basis. The South African Audience Research Foundation (SAARF) maintains up-to-date figures on public consumption of the mass media. These figures can help MMC programme managers plan which media to use in campaigns. They are also

used by media owners to determine the cost of advertising in their media – the bigger and wealthier the audience, the higher the cost of advertising.

Figure **8** indicates that television is the most widely consumed medium, closely followed by radio, while newspapers are only read by about one in four people during the course of a week (37).



Source: www.saarf.co.za

Figure 8: Percentage of SA population using various forms of mass media

There are basically two ways of engaging these media:

1. Securing the interest of their journalists so that they will feature a story for free in one of their programmes or in the newspaper. This is known as editorial coverage and requires convincing journalists that the topic of "story" is of genuine interest to their audiences.
2. Paying for TV or radio broadcast time or space in a newspaper. The most common form of paid media coverage is conventional advertising but there are also more flexible forms.

There is no simple answer to the question: which types of mass media are best for raising public awareness of MMC?

No medium is innately better or worse than another. The value of each medium to a particular campaign should be determined by the following questions:

- Does the medium reach your target population and is it trusted by them?
- Do you need repeated exposure to the audience through adverts or is one comprehensive editorial story enough?
- Do you need to interact with your target audience, or is one-way communication suitable?
- What is the overall cost of advertising in a medium and what is the unit cost per person reached?
- What is the cost of producing the advert or other content for that medium?

- What is the call to action - what should the target audience do once they have seen the communication?

See section 9 for more details on costing.

6.4.1. Television

Of all communication media in South Africa, television has the widest reach with more than 90% of the adult population accessing television. It offers access to its audience through:

- Advertising.
- Editorial (news and talk shows).
- Drama.

However, TV viewership is fragmented over an increasing number of channels so it is necessary to advertise on or engage with a combination of channels to reach a high proportion of viewers.

Television is the most expensive medium in terms of production of adverts and purchasing of advertising airtime. However, the returns are good because the audiences are large and therefore the cost per person reached can be low.

Most TV channels have a national footprint, but community TV channels have emerged in major cities in recent years. This implies TV may be an option both for nationally-planned MMC communication campaigns and for some localised campaigns.

6.4.1.1. Advertising

Television advertising entails short commercials – usually 10 seconds to 60 seconds in length – that are broadcast on network TV channels. A communication campaign manager wishing to advertise on TV would have two major tasks: getting the advert produced and purchasing television advertising.

In terms of production, adverts have to work hard to attract and retain the attention of viewers while still remaining true to the evidence-based messages of the MMC campaign. Given the investment in creating and broadcasting an advert, the P-Process should be rigorously applied to make sure that the material is evidence based, that the messages are tailored correctly. Ensure that the adverts are pre-tested with the target audience members before they air to ensure they convey the intended message and are positively received.

Buying TV advertising can be fairly complex and involves a series of calculations based on which programmes the target audience is most likely to watch and the particular cost of advertising during those programmes. There are professional media companies that have software to work out how to reach specified audiences at the least possible cost and it is usually advisable to utilise such companies.

Key considerations when planning a TV advertising strategy are reaching large numbers of your target audiences and ensuring they view the advert with sufficient frequency. Conventional wisdom in the advertising industry is that an advert needs to be viewed four times before the viewer fully comprehends its message. The cost of buying enough air time to achieve high frequency can be very substantial.

6.4.1.2. Editorial

News bulletins, documentaries and talk shows constitute the editorial side of television – as compared to the entertainment side. Editorial is most useful when there is new research on MMC or a new campaign. This is likely to get the attention of a programme producer and a spokesperson for the MMC programme may be filmed or invited into the studio to participate in a talk show.

Editorial coverage offers the extremely valuable airtime because it is free. It is also usually possible to give more information and more nuanced messaging than advertising permits.
It is necessary to reach out to TV producers or news journalists in order "sell" stories to them. The best way to do this is by writing a short media release – a summary of what interesting information you have to offer the TV programme – and sending it to the producer. Every media release should also be followed up with a phone call because there is competition for editorial airtime and it is necessary to lobby gently for your story.

Information on how men can access MMC services should be included in every media release although there is no guarantee that this will be broadcast.

Once again, there is a need to target channels and programmes that are watched by the audiences whom the MMC programme needs to reach.

6.4.1.3. Drama

Drama in this context includes the use of locally-produced short stories, sitcoms and plays for health promotion. South Africa has a globally respected record of high quality prime-time health-focused television drama. It is also possible to develop a story line in a popular drama that carries a public health message. This can either be purchased from the television station, which gives the campaign managers a high level of control of the narrative or it can be negotiated with a drama producer.

Irrespective of the television format selected, it is crucial that the MMC messaging is not lost in the creative packaging of the information.

6.4.2. Radio

The combined reach of national, regional and community radio stations is also extensive in both urban and rural settings. Radio is known to have very loyal listeners who often listen throughout the day.

Total radio listenership is fragmented across many stations. Therefore, a national MMC campaign would need to enlist a large number of stations, but some regional campaigns and most district-level campaigns could reach a high proportion of the target audience with just a few stations.

Like television, radio may be utilised for advertising or editorial purposes. The same general rules apply in terms of the production of adverts, the planning of advert placement, ensuring frequent exposure to adverts, and the need to win the interest of journalists in order to secure free editorial coverage.

However, there are some important differences:

- Production of adverts for radio is generally cheaper and it is also possible to simply supply the text for a "live read" done by the presenter or disc jockey (DJ).
- There is more extensive use of local languages in radio and this makes the content more accessible and relatable to audiences.

From an editorial point of view, radio has quite a high proportion of educational programmes and slots that deal with "soft" topics as opposed to the latest news. This increases the chances of a radio producer accepting an MMC story that is informative rather than news-focused.

Community radio is especially likely to offer additional editorial exposure to a campaign that purchases some paid advertising.

6.4.3. Print media

Newspapers are the most useful of the print media for dissemination of information on MMC. The advantage of newspapers is that the information can easily be clipped and stored for later reference. This information can be relatively detailed and can incorporate graphics for added clarity.

However, MMC demand-generation managers need to investigate the literacy levels and newspaper consumption patterns of their target audiences before investing in newspaper advertising or putting a lot of effort into getting editorial coverage from print journalists.

The distribution systems of newspapers are extraordinarily efficient, and it is possible – for a fee – to use these to distribute IEC materials as inserts.

The media release is even more important when it comes to print media, as it is possible for a journalist to write an entire story just by reading a media release. Unlike TV and radio, there is no *absolute* need for visuals or for an interview with a spokesperson – although many print journalists still like to add interviews and get photos to accompany their stories.

6.4.4. Out-of-home media

Out-of-home (OOH) media refers to a range of advertising platforms that the public is exposed to outside of the home environment. In South Africa the category includes billboards, taverns posters, point of sale campaigns (in supermarkets, spaza shops and small businesses like hair salons), wall murals, commuter TV (screens where commuters wait for transport and in vehicles), and internal and external branding of taxis and buses.

OOH materials require short, simple messages – making it crucial to get the message right. Testing of both the message and the visual design are critical.

OOH media are often used to supplement radio and/or TV advertising. The medium has the advantage of speaking to a local audience and is good for advertising local services because people may be exposed to it numerous times. However, there is also the risk that OOH media can simply blend into the background when placed in busy environments with competing visual stimuli, such as taxi ranks or train stations.

Different OOH media have unique advantages:

- Exterior taxi branding (wrapping) has the advantage of moving through the environment catching the eye of people in different neighbourhoods.
- Internal taxi and bus advertising has a captive audience who have time to write down phone numbers or send an SMS for a “please call me”.
- Commuter TV involves outdoor screens at taxi ranks and often reaches large numbers of commuters who spend some time waiting for their transport, offering advertisers good value for money.

6.5. SOCIAL AND DIGITAL MEDIA

Social and digital media refer to interactive platforms that allow users to share ideas and information with a network of contacts. These platforms have the potential to improve reach, increase engagement, and provide tailored experiences to particular individuals and communities (30).

The use of social and digital media has been on the increase in public health and health promotion because it can overcome geographic and physical barriers to information (31). Some of the social media platforms that implementers can utilise to generate demand for MMC are:

- Facebook which can be used to share information about MMC, engage individuals within particular networks and advertise MMC campaigns. Facebook can also be used as a booking mechanism.
- Twitter: implementers can use this platform to create a network of followers who "like" and "retweet" posts about MMC. Twitter has a limit on message length and should ideally be used for up-to-the-minute discussions of current events, such as campaigns and activations.
- Hashtags: are a means of organising conversations on social media platforms. They can provide context for comments on Facebook and Twitter and be used to initiate or continue conversations.
- WhatsApp: can be utilised to create support groups for men who have been circumcised – for example to share post-operative coping strategies.
- Instagram: can be used to share photos and videos of a campaign or activation so that followers can view these and comment.

Managing a social media campaign may include the use of paid advertising, boosting posts on a page or account you own, directly messaging with users and collaborating with a popular local person (hairdressers and DJs are found to have the most active pages in rural areas) and asking them to advocate by post about MMC to their followers.

Given the wide range of social and digital media available for utilisation, it is important that implementers ensure that messages about MMC shared on the various platforms are consistent and information is correct. Real-time use of social media is key for effectively delivering messages and ensuring prompt responses to commenters (especially negative detractors of MMC). Authenticity and personal engagement is key for successful social media engagement. In addition, implementers need to understand and match the social media platform with the target audience and context. It is important to be aware that data costs can make Instagram, Facebook and Twitter inaccessible to many people.

6.6. IEC MATERIALS PRODUCTION

The availability of adequate quantities of suitable printed materials is absolutely essential to enable social mobilisers to operate effectively. They need:

- Pamphlets in appropriate languages to leave with men they have interacted with in order to allow them space to clarify and absorb the information in their own time and perhaps share it with friends, family members and intimate partners. Ideally the leaflet should have contact details for booking – either a call centre or a local MMC facility.

- Posters or flipcharts that can be used when talking to a small group of men – for example when visiting a workplace or participating in a community health day. These not only help keep the mobiliser focused and on-message, but pictures assist audience comprehension and – since audience members are employing hearing *and* vision – also result in better recall.

During the development phase, leaflets, posters and flipcharts need to be pre-tested with a sample of men similar to the intended audience in order to ensure that the language used is easily understood and the illustrations convey the right meaning. When materials are translated, the translated versions should also be pre-tested to ensure the original meaning has been retained, that the language is

similar to the spoken language of the audience (rather than very formal and academic), and that technical terms have been translated in a way that is understandable to the audience.

It is preferable for these materials to be developed by national or provincial health departments because writing, illustration, design and pre-testing can become quite costly and also because standard materials will contribute to consistent messaging. If they are printed centrally in large quantities major savings can be made on printing costs.

6.7. ADVOCACY

Advocacy is a process that engages stakeholders and mass media in order to promote a particular issue or policy. It has been described as “an action directed at change . . . putting a problem on the agenda, providing a solution to that problem, building support for the solution and for the action necessary to implement the solution” (36).

Advocacy is usually aimed at influential people or at mobilising popular opinion to exert pressure on those in authority. This strategy recognises that the objectives of the MMC programme require advocacy, particularly in terms of addressing the intersection between MMC and traditional practices.

Advocacy and resulting policy measures can in some instances be more effective than communication alone in achieving behaviour change across a priority population. Advocacy could be used strategically to build support for policies and service innovations identified in the MMC strategy.

There are several tools which can assist an organisation to decide whether it should engage in advocacy and if so, what issues it should focus on.

Some key advocacy processes together with examples of interventions or activities that could be undertaken locally are outlined in the table below.

Table 7: Advocacy aims and examples of interventions

Advocacy aims	Interventions
Spark dialogue on issue in broader society through media interviews and articles.	Prepare materials such as opinion pieces and interview messaging, and engage with regional and community media.
Inform and mobilise influential role players, such as traditional and community leaders.	Prepare and distribute advocacy materials, such as evidence-based policy briefs, to leadership.
Engage in discussion with relevant audiences.	Conceptualise and host small events, meetings and workshops. Use these events to gain media coverage.

6.8. SUMMING-UP ON COMMUNICATION INTERVENTIONS

Table 8 provides a summary of all the communications methods discussed in this section and outlines the advantages and disadvantages of each method and how it is best applied to MMC demand generation.

Table 8: Summary of communication methods

Communication method	Advantage	Disadvantage	Best use in MMC demand generation	Who should implement
Social mobilisation	Ability to tailor messages to individual needs, provide support, address barriers	Requires significant human resources to run an effective mobiliser programme	Mobilisers should be used in every district	Each district should manage its local mobilisers
Call centres	Can follow-up with leads and provide one-on-one support	Substantial infrastructure is required to operate	Mobilisers and mass media should refer potential clients to a call centre for information and bookings	Best managed nationally with every facility providing accurate information for effective booking system
Activations	Build awareness of MMC and opportunities to interact with audience	Potentially expensive and requires human resources to plan and execute well	Can leverage off existing local community events	Best organised at district level in order to engage the local community
Television	Very wide reach, good adverts can be memorable	Very costly	Maintain high awareness of MMC and encourage conversations about MMC	Because of high cost, best implemented at a national level where bulk-buying may achieve some savings
Radio	A cost-effective method to reach audiences, from national to local level	Recall of radio messages can be difficult, requires very distinct messaging and call to action	National and regional radio: back adverts with educational editorial. Local radio: provide specific info on local MMC clinic – hours, contact details	Regional radio campaigns should be executed at provincial level, while community radio interventions can be planned at district level where staff understand audience preferences (with provincial support where needed)
Print media	Clients can keep adverts	Newspapers advertising	Editorial coverage may be	Print adverts in regional papers should

Communication method	Advantage	Disadvantage	Best use in MMC demand generation	Who should implement
(newspapers and magazines)	and articles and refer to them at a later date	can be costly. Audience literacy and price of some papers may be a barrier	obtainable as is often more credible than advertising. Advertising in community newspapers may be affordable and they are generally free to public	be managed at provincial level, while community newspaper interventions can be planned at district level where staff understand audience preferences (with provincial support where needed)
Out-of-home advertising	Good for advertising local services	Can be lost in crowded visual landscape	Provide succinct message about where to get circumcised in local area	Provincial coordination of OOH is probably best, with district input to ensure relevant placement and correct service information
Social and digital media	No cost to register and engage men on platforms where they may spend a lot of time	Instantaneous communication which requires resources to monitor *constantly* and interact with users	Deliver a consistent MMC message nationally at a low cost	Best managed nationally to ensure consistent messaging and constant monitoring. All services need to support national by providing accurate information down to facility level
IEC materials	Essential to support inter-personal communication. Facilitate decision-making process for members of audience	Rely to some extent on literacy and require good stock-management systems	Deliver consistent message, allow audience members to interact with message in own time and to share information, and also enhance communication capacity of mobilisers	IEC materials should be developed and printed at a national level to ensure quality control and message consistency. A national system should be developed for ordering of materials by provinces, districts and implementing partners
Advocacy	Engages influencers to encourage men to take up MMC and to leadership to make policy that facilitates MMC	Requires time and human resources to maintain meaningful interactions	Can be used to ensure that traditional initiation customs include circumcision that is done medically and safely	Should be supported at a provincial level, understanding the different cultural requirements in each province

7. MANAGING THE RESPONSE: PROGRAMME MONITORING AND EVALUATION

The M&E processes described in this section are designed to provide information to track the implementation and outputs of the MMC demand-generation programme and to measure the programme's effectiveness.

Monitoring refers to the systematic, long-term collection of information to track progress in implementing demand-generation activities. During the planning phase for MMC, a monitoring framework is developed which links demand-generation activities to set indicators. This ensures that routinely collected data is suited to describing the progress. Indicators enable managers and implementers to compare results against targets and identify both successful approaches and problems that need to be remedied. Monitoring answers the question: "Are we delivering?".

Evaluation is performed periodically, typically quarterly or annually. It is an objective assessment of the demand-generation programme, its design, implementation and results. Evaluation looks at the relevance, effectiveness, efficiency, impact and sustainability of demand-generation interventions. It links specific interventions to the broader programme objectives and provides evidence of why targets and outcomes are or are not being achieved. Evaluation answers the question: "What is happening as a result of our interventions?".

M&E is important for both managers and implementers involved in demand generation. It provides managers with information on what is working and what is lacking in impact. This helps managers make appropriate adjustments to programme delivery in accordance with their responsibilities as managers.

M&E also allows implementers to build their expertise and knowledge by identifying gaps and developing better approaches – and by sharing these experiences to contribute to the development of best practices.

M&E frameworks and processes therefore form a crucial link between decision makers, managers, and implementers involved in the demand-generation programme. M&E also provides information that contributes towards the transparency and accountability of the programme.

In order to derive these benefits, data collection and synthesis processes must be appropriately linked with the programme's theory of change so that it not only measures demand-generation interventions but also shows whether the expected outputs, outcomes and impacts are occurring. The M&E framework (Table 9) aims to achieve this. It provides a broad overview of the programme indicators, their method of measurement, frequency of measurement, required disaggregation, and the person(s) responsible for collection.

Based on the framework, standardised data collection and synthesis tools will then be developed by the national MMC programme & ACSM directorate for all levels of the programme. Standardisation of these tools is crucial for horizontal assessment – that is, across all implementers – and vertical assessment, which considers all management and implementation functions at national, provincial, district and local levels.

7.1. MONITORING AND EVALUATION FRAMEWORK

The M&E framework in Table 9 converts various elements of the theory of change in section 3 into process, output, outcome and impact indicators. These indicators have been carefully considered for monitoring the demand-generation component of the MMC programme. An attempt has been made to provide a clear picture of implementation without unduly burdening those responsible for data collection.

The chosen indicators will provide the information required to answer the following overarching monitoring questions:

- What is the number and percentage of men reached by social mobilisers?
- What number and percentage of men have been successfully booked for MMC services by social mobilisers?
- What number and percentage of men have been successfully booked for MMC services by call centre agents?
- What is the number and reach of community-based media campaigns aimed at generating demand for MMC, per campaign type?
- What is the number and reach of national mass media campaigns aimed at generating demand for MMC, per campaign type?
- What is the number of meaningful engagements with national social media campaigns developed to generate demand for MMC?

Prior to programme implementation, the national MMC programme and ACSM directorate will convene to set annual targets for each indicator.

Table 9: Monitoring and evaluation framework for the MMC demand-generation programme

Level	Indicator	Measurement method	Frequency of measurement	Disaggregation	Responsible for data collection
Impact	Number of MMC procedures performed	DHIS	Annual	Age group, province	National Director: MMC
	Number of circumcised men who used a condom at last sex	Survey data	Three-yearly	Age group, province	
Outcome	Number of men who intend to get circumcised in the next 12 months	Survey data	Three-yearly	Age group, province	National Programme Manager: MMC
	Number of people with favourable attitudes towards MMC	Survey data	Three-yearly	Sex, age group, province	
	Number of people who understand the benefits of MMC	Survey data	Three-yearly	Sex, age group, province	
Output/ intervention	*Social mobilisers*				
	Number of social mobilisers recruited and trained	Programme data	Quarterly	District	District MMC Coordinators
	Number of men reached by social mobilisers	Programme data	Monthly	Age group, district	
	Number of IEC materials distributed by social mobilisers	Programme data	Monthly	District	
	Frequency of discussions with men about barriers to accessing MMC	Programme data	Monthly	Key message, age group, district	
	Number of men linked to MMC services by social mobilisers	Programme data	Monthly	Age group, district	
	Number of men who circumcised after being linked to the service by social mobilisers (conversion rate)	Programme data	Monthly	Age group, district	
	Call centres				
	Number of call centre agents recruited and trained	Programme data	Quarterly	National	National Demand Generation
	Number of leads who contact MMC call centres	Programme data	Monthly	Age group, district	

Level	Indicator	Measurement method	Frequency of measurement	Disaggregation	Responsible for data collection
	Number of leads contacted by MMC call centre agents	Programme data	Monthly	Age group, district	Coordinator: MMC
	Frequency of discussions with leads about barriers to accessing MMC	Programme data	Monthly	Age group, district	
	Number of leads booked to MMC services by call centre agents	Programme data	Monthly	Age group, district	
	Number of leads who got circumcised after being linked to the service by a call centre agent	Programme data	Monthly	Age group, district	
	Community-based media				
	Number of community campaigns, per type (TV, radio, print)	Programme data	Monthly	District	District MMC Coordinators
	Number of community activation events	Programme data	Monthly	District	
	Number of community event participants	Programme data	Monthly	Age group, district	
	Mass media				
	Number of mass media campaigns, per type (TV, radio, print)	Programme data; ad hoc data to assess reach	Monthly	Language, viewership/listenership	National ACSM, Phila
	Social media				
	Number of people who engage with the campaign profile (active followers, profile visits)	Programme data	Monthly	Age group, sex, social media platform	National Demand Generation Coordinator: MMC
	Number of campaign posts	Programme data	Monthly	Key message, sex, social media platform	

Level	Indicator	Measurement method	Frequency of measurement	Disaggregation	Responsible for data collection
	Number of post interactions (likes, shares, comments)	Programme data	Monthly	Age group, sex, social media platform	
	Number of leads who got circumcised after being linked to the service via social media	Programme data	Monthly	Age group, social media platform	

7.2. DATA COLLECTION

7.2.1. Programme interventions (output level)

Based on the indicators outlined in the M&E framework above, standardised data collection and reporting tools will be developed under the guidance of the NDoH to capture output-level data on a monthly basis. Some of the key indicators will also be reported through the DORA (a National Treasury reporting framework) to ensure compliance and accountability in the implementation of the strategy.

As outlined in Figure 9, implementers will be responsible for collecting data on social mobilisation, call centre and community media interventions, and reporting this to district MMC coordinators. Reporting will therefore first take place at the community level and reported at a facility to the Facility Manager, public relations officer (PRO) or MMC champion, who then sends weekly/monthly reports to the District HAST/MMC Coordinators. Districts will compile data and undertake quality assurance of data and submit this to the provincial MMC & ACSM managers/coordinators. Provinces will compile data, perform quality assurance, and report the data to the national MMC programme and ACSM directorate on a quarterly basis.

Data for mass media and social media interventions will be collected and reported at national level. All data, across district, provincial and national levels, will be stored in a centralised database managed by the NDoH.

7.2.2. Surveys and special studies (outcome and impact level)

Surveys and special studies will be conducted every three years, starting from year three (2013) of programme implementation, in order to evaluate the impact and outcomes of demand-generation interventions.

The National Demand Generation Coordinator will oversee execution of these studies by ensuring either that indicators are added to existing HIV communication surveys (such as those conducted by the Human Sciences Research Council and Statistics SA), or that stand-alone surveys are contracted to an external party.

7.3. DATA USE

Dashboards will be established for each district and province to provide a visual representation of progress in implementing demand-generation activities and the respective contribution of these to uptake within the respective districts. The focus will be the six overarching monitoring questions mentioned above and the dashboards will track implementation progress against targets. Furthermore, the dashboard will assist in identifying successful demand-generation modalities and strategies that provide limited impact to be re-assessed.

The National Demand Generation Coordinator for MMC will oversee dashboard updates of all 52 districts on a monthly basis. District, provincial and national teams will then have real-time access to these dashboards to allow for continued review and use of data by all stakeholders.

The dashboards will be formally reviewed during quarterly meetings held by the National Demand Generation Working Group and attended by implementing partners and other relevant stakeholders. These meetings will ensure continued assessment, identification and resolution of challenges, and collaborative adjustment of the programme as needed.

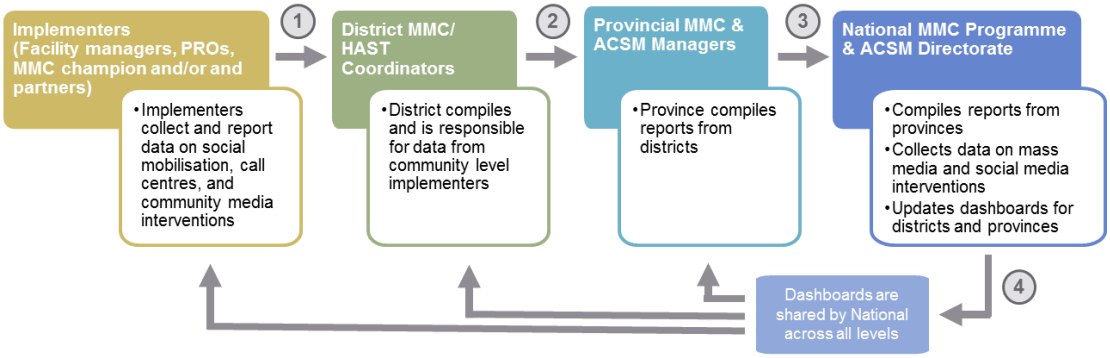


Figure 9: **Monthly flow of data for programmatic interventions**

8. GOVERNANCE

The following section outlines the government structure for the MMC programme and the roles and responsibilities of each level as it relates to demand generation. This creates a clear line of accountability across the programme. Success of the overall programme lies in the appropriate staffing and leadership at each level to drive the programme forward.

8.1. STRUCTURES

Responsibility for the MMC programme will vest in managers at four levels:

- At national level, the MMC programme and the ACSM directorate will be responsible for leading the coordination of the strategy and operational plan, as well as M&E.
- At provincial level, this role will be assumed by MMC and ACSM managers/coordinators under the guidance and leadership of HAST managers.
- At district level, all activities will be coordinated by district MMC coordinators or district HAST coordinators under the guidance and leadership of the district HAST managers.
- At sub-district level, sub-district HAST coordinators will be responsible for coordinating the facilities within the sub-district.
- At facility level, facility managers, PROs or nominated MMC champion will be tasked with coordinating and leading the implementation of the programme.

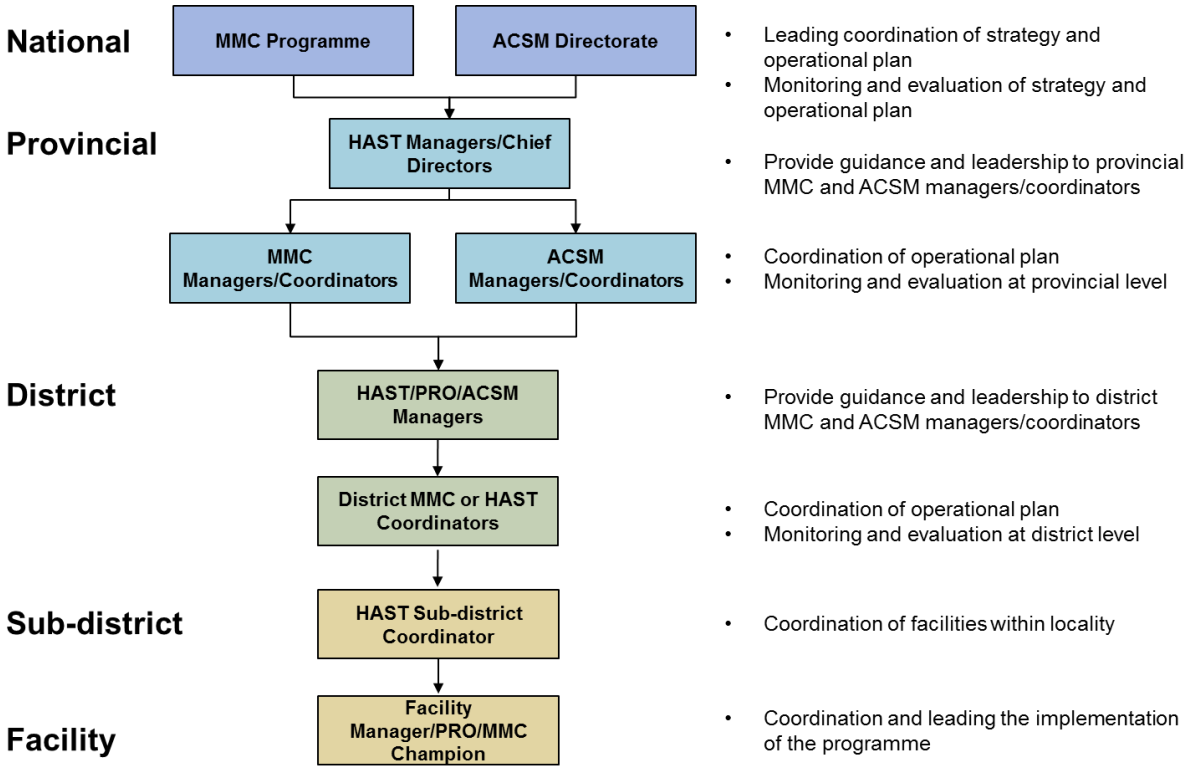


Figure 10: MMC programme structure and primary responsibilities

The NDoH will be tasked with conducting quarterly meetings of the National Demand Generation Working Group to coordinate and monitor the implementation of the MMC demand-generation strategy and its effectiveness. These meetings will take place at the NDoH offices and will also serve as a forum where the NDoH can share relevant updates, provide guidance

and hold stakeholders accountable for the implementation of the demand-generation strategy. It will be used to share best practices and to identify and mitigate challenges being experienced. These meetings will be chaired by the national MMC Programme Manager or national MMC Demand Generation Coordinator.

This Working Group will comprise of a dedicated MMC representative from the following stakeholders:

- NDoH MMC programme
- NDoH ACSM
- Phila
- HIV Prevention Strategies: HTS, PMTCT
- Primary Health Care (PHC)
- Adolescent and Youth-Friendly Services (AYFS)
- Maternal and Child Health programmes
- Provincial MMC Programme
- Provincial ACSM
- Other Government Departments (DPSA, DBE, DCS, DoD)
- MMC implementation partners (PEPFAR and SA-government funded)
- South African National AIDS Council (SANAC) Secretariat
- Traditional sector (CoGTA)
- Religious sector (South African Council of Churches)
- Private sector (SABCOHA)
- PEPFAR (CDC, USAID)
- PEPFAR demand generation partners

The above list is not exhaustive and other relevant stakeholders can be added on an as-needed basis provided their buy-in and contributions are beneficial to the working group on a whole.

Table 10 outlines the reporting structure from district level up to national level. Just as crucial, however is the distillation of the aggregated information to be disseminated back to district level to ensure the data is effectively used to effect change where necessary. A reporting template will be developed by national and shared with all parties concerned for consistency in reporting.

Table 10: Reporting structure by government level

Responsible for report	Action	Date	Report sent to	Purpose
District MMC/HAST coordinator or District HAST Manager	Email report of activities conducted during month	Last day of the month	Provincial MMC Manager/Coordinator ACSM Manager/Coordinator *Copying:* HAST Manager District Health Service Manager or Primary Health Care Manager	Generate monthly dashboard to understand district performance, accomplishments and potential gaps
Provincial MMC Coordinator	Produce consolidated report	10th day of subsequent month	National MMC Programme Manager *Copying:* National MMC Demand Generation Coordinator	Reports must not only be reviewed at the national quarterly meetings, but filter back to district level and reach relevant programme leads

Responsible for report	Action	Date	Report sent to	Purpose
National MMC Demand Generation Coordinator National ACSM Directorate	Quarterly report	Five days before quarterly meeting	National MMC Director MMC Programme Manager	The report is to be discussed at the National Demand-Generation Working Group to assess national demand generation performance

8.2. MANAGEMENT RESPONSIBILITY

Responsibilities for managing the national MMC demand-generation programme and reporting lines from national level through to facility level are set out in Table 11.

Table 11 Responsibility for managing the demand-generation programme:

Position	Responsible for	Activities	Reports to	Reports on
National Director: MMC	**Coordination and monitoring** Coordinating and monitoring the implementation of the MMC demand-generation strategy **Advocacy** Using this strategy as an advocacy tool to obtain buy-in from all relevant sectors, government departments and health programmes	Submission of quarterly progress report Convening of advocacy meetings with key health programmes and other relevant stakeholders	Chief Director and Deputy Director-General	Number of MMC procedure performed Number of circumcised men who used a condom at last sex
National Programme Manager: MMC	**Coordination and monitoring** Coordinating and monitoring the implementation of the MMC demand-generation strategy **Advocacy** Using this strategy as an advocacy tool to obtain buy-in from all relevant sectors, government departments and health programmes **Implementation** Overseeing the development of an operational plan for MMC demand- generation and ensuring alignment with provincial conditional grant business plans Ensuring integration of MMC with PHC and other key health programmes	Chairing/co-chairing quarterly progress meetings Reviewing provincial reports and approving quarterly progress report Convening advocacy meetings with key health programmes and other relevant stakeholders. Reviewing national operational plan for MMC demand generation	National MMC Director	Number of men who intend to get circumcised in the next 12 months Number of people with favourable attitudes towards MMC Number of people who understand the benefits of MMC, including the benefit of reduced HIV risk

Position	Responsible for	Activities	Reports to	Reports on
National Demand Generation Coordinator: MMC	**Coordination and monitoring** Coordinating and monitoring the implementation of this strategy **Implementation** Ensuring the development of an operational plan for MMC demand generation and its alignment with provincial conditional grant business plans Ensuring the integration of MMC with PHC and other key health programmes Ensuring that strategies are aligned to the national demand-generation strategy	Chairing/co-chairing quarterly progress meetings Reviewing provincial business plans for alignment of demand-generation activities with the national demand-generation strategy Reviewing provincial reports Compiling quarterly progress reports Convening advocacy meetings with key health programmes and other relevant stakeholders Reviewing national operational plan for MMC demand generation	National MMC Programme Manager and MMC Director	Number of call centre agents recruited and trained Number of leads who contact MMC call centres Number of leads contacted by MMC call centre agents Frequency of discussions with leads about barriers to accessing MMC Number of people who engage with the campaign profile (i.e. active followers, profile visits) Number of social media campaign posts Number of post interactions on social media (likes, shares and comments)

Position	Responsible for	Activities	Reports to	Reports on
National ACSM	**Coordination and monitoring** Supporting the MMC directorate in coordinating and monitoring the implementation of this strategy Monitoring the implementation of the national demand-generation strategy **Implementation** Ensuring that all MMC demand-generation campaigns are aligned with the demand-generation Strategy and operational plan Ensuring integration of MMC with primary health care and other key health programmes	Chairing/co-chairing quarterly progress meetings Reviewing provincial reports Reporting on progress of MMC campaigns Reviewing the national operational plan for MMC demand generation Convening advocacy meetings with key health programmes and other relevant stakeholders	National MMC Programme Manager and MMC Director	Number of mass media campaigns, by channel of communication
Phila	**Implementation** Ensuring that the Phila campaign for MMC is aligned with the national demand-generation strategy Assisting in the implementation of MMC demand-generation campaigns in all provinces and inform the development of tailored demand-generation campaigns Monitoring the implementation and effectiveness of MMC demand-generation campaigns Prioritising the districts without PEPFAR support	Developing MMC campaigns aligned with this strategy Developing a national MMC demand-generation implementation plan aligned with the demand-generation strategy and national operational plan Conducting advocacy meetings with all provinces and relevant stakeholders to solicit buy-in Conducting provincial roadshows to cascade implementation plans and campaigns and build provincial capacity to implement MMC demand-generation campaigns Implementing Phila MMC campaigns in the provinces	National ACSM and National MMC Demand Generation Coordinator	Number of mass media campaigns, channel of communication

Position	Responsible for	Activities	Reports to	Reports on
Provincial MMC Manager or MMC Coordinator	**Coordination and monitoring** Coordinating and monitoring the implementation of the demand-generation strategy **Implementation** Ensuring that the appropriate MMC demand-generation activities (in accordance with the demand-generation strategy), are included and budgeted for in the district implementation plans (DIPs), district health plans (DHPs), micro-plans and provincial conditional grant business plans Developing a provincial MMC demand-generation implementation plan that is aligned with this strategy Ensuring integration of MMC with PHC services and other key health programmes Ensure linkage and referrals to MMC from relevant public health services, and from MMC to ART, TB, STI and other services relevant to the client Ensuring that all MMC staff and community health workers are adequately trained in demand-generation for MMC and have the necessary tools Ensuring adequate supplies of IEC materials and other demand-generation resources **Advocacy** Championing and cascading this strategy to all relevant stakeholders Using the strategy as an advocacy tool to obtain buy-in from all relevant sectors, government departments and programmes	Reviewing national operational plan for MMC demand generation Reviewing district reports Chairing/co-chairing monthly progress meetings Reviewing and approving monthly progress report Convening advocacy meetings with relevant stakeholders Developing a provincial MMC Demand-generation implementation plan that is aligned with the demand-generation strategy Annual updating of DIPs, DHPs, micro-plans and business plans in respect of demand-generation activities for the next financial year Appointing sufficient MMC doctors and staff to conduct the expected number of procedures Appointing sufficient mobilisers Procuring and disseminating MMC demand-generation materials	Provincial HAST Manager, national NDoH structures	Culmination of reporting from districts

Position	Responsible for	Activities	Reports to	Reports on
Provincial ACSM units	**Coordination and monitoring** Coordinating and monitoring the implementation of the demand-generation strategy **Implementation** To ensure integration of MMC demand generation with other prevention programmes Working with MMC programme to ensure that the appropriate MMC demand generation activities (in line with the demand-generation strategy and operational plan), are included and budgeted for in the DIPS, DHPs, micro-plans, and provincial conditional grant business plans Working with the MMC programme to develop a provincial MMC demand generation implementation plan that is aligned to demand-generation strategy To ensure adequate supply of IEC materials and other demand generation resources **Advocacy** Championing and cascading the demand-generation strategy to all relevant stakeholders	Chairing/co-chairing quarterly progress meetings Reviewing district reports Reporting on progress of MMC demand-generation campaigns Convening advocacy meetings with key health programmes and other relevant stakeholders Appointing MMC district coordinators in districts where there are none Developing and/or procuring and disseminating MMC demand-generation materials	Provincial HAST Manager, Provincial MMC Manager/Coordinator	Culmination of reporting from districts

Position	Responsible for	Activities	Reports to	Reports on
District MMC or HAST Coordinator Sub-district Coordinator	**Coordination and monitoring** Coordinating and monitoring the implementation of the demand-generation strategy **Implementation** Ensuring that the appropriate MMC demand-generation activities (in line with the strategy) are included and budgeted for in the DIPs, DHPs, micro-plans and conditional grant business plans Developing a district MMC demand-generation implementation plan Ensuring integration of MMC with PHC and district health services and other key health programmes Ensuring that all MMC staff and community health workers are adequately trained in demand generation for MMC and have the necessary tools Ensuring adequate supplies of IEC materials and other demand-generation resources **Advocacy** Championing and cascading the demand-generation Strategy to all relevant stakeholders Using the demand-generation strategy as an advocacy tool to obtain buy-in from all relevant sectors, government departments and programmes	Submitting district progress reports Chairing/co-chairing monthly progress meetings Reviewing and approving monthly progress report Convening advocacy meetings with relevant stakeholders Developing a provincial MMC demand-generation implementation plan that is aligned with the demand-generation strategy and MMC demand-generation campaign Appointing sufficient MMC doctors and staff to conduct the number of procedures expected Appointing sufficient mobilisers Procuring and disseminating MMC demand-generation materials	District HAST Manager	Number of social mobilisers recruited and trained Number of men reached by social mobilisers Number of IEC materials distributed by social mobilisers Frequency of discussions with men about barriers to accessing MMC Number of men linked to MMC services by social mobilisers Number of men who got circumcised after being linked to the service by social mobilisers Number of community radio campaigns Number of community activation events Number of community event participants

Position	Responsible for	Activities	Reports to	Reports on
Facility Manager/ PRO/ MMC Champion	**Coordination and monitoring** Coordinating and monitoring the implementation of the strategy/plan Monitoring and evaluating performance of community health workers **Implementation** Ensuring that the appropriate MMC demand-generation activities (in line with the strategy), are included and budgeted for in the DIPs, DHPs, micro-plans and provincial conditional grant business plans Developing a facility MMC demand-generation implementation plan and nominate an MMC champion to lead MMC Ensuring integration of MMC with PHC and district health services and other key health programmes Ensuring that all MMC staff and community health workers are adequately trained in demand generation for MMC and have the necessary tools Ensuring adequate supplies of IEC materials and other demand-generation resources **Advocacy** Championing and cascading the demand-generation strategy to all relevant stakeholders Using the strategy as an advocacy tool to obtain buy-in from all relevant sectors, government departments and programme	Developing an MMC implementation plan that is aligned with the demand-generation strategy and costed in the business plans Compiling monthly progress reports Conducting status update meetings on MMC performance and demand-generation activities at the facility with all relevant local stakeholders Training all MMC service delivery and demand-generation staff in demand generation Conducting an orientation workshop on the demand-generation strategy Establishing a facility M&E system for demand generation Appointing sufficient MMC doctors/staff to conduct the expected number of procedures Appointing sufficient mobilisers Procuring and disseminating MMC demand-generation materials	District HAST Manager, DMT, provincial structures	Referrals into clinics (Mobilisers asking clients "how did you hear about MMC?")

9. COSTING

The following section outlines budget considerations and minimum costs for each communication channel that has been described in section 6. It is important to note that these costs will vary based on the province and district and should be considered as a guideline. The intent of this section is to assist implementers in assessing their budgets and how to allocate limited resources towards the most effective demand-generation activities in the catchment area. All costs listed below are subject to change and reflect the purchasing power of the ZAR as of 2017.

9.1. INTERPERSONAL COMMUNICATION

9.1.1. Social mobilisation

As outlined in section 6, social mobilisation is essential to generating demand for MMC in order to directly reach men on a one-on-one basis, increase their knowledge about MMC and link them to services. There are important cost consideration for social mobilisers, including:

Training

The training costs for mobilisers will vary across different contexts and for different implementers. It is recommended that training is provided in groups of 20-25 people at a time. However, one implementer may require training for fewer people (i.e. 20 people) while another may require training for the maximum number (i.e. 25 people). In this case, both these implementers will incur different costs related to training.

Often, the venue for demand generation training is supplied by the NDoH and is therefore free. However, implementers can incur costs depending on their preferences and/or preferred training location. The distance travelled by attendees will also vary and may require reimbursement. The costs provided below are possible cost ranges that can guide implementers when they implement training and are subject to change. It is important that implementers aim to work within their allocated budget but however, provide training that not only aims to minimise costs but that ensures that training is provided in an effective and efficient way.

Supply and Maintenance

There are various resources that are required for social mobilisers when they are on field. For example, uniform, cell phones etc. The minimum costs for some of these resources have been outlined below. However, each implementer will incur different costs depending on their unique requirements.

Employment costs

These costs are related to the monthly remuneration/compensation for the time spent by social mobilisers, recruiters and MMC support staff on demand generation activities. Again, the costs provided are an example of the employment costs incurred by one implementer.

Example: MMC benchmark costs for expenditure on social mobilisation	
Item	Unit Cost
Costs of training mobilisers and team leaders. Include (per training):	R 2,700 – R 6,000
Venue hire (X 3 days training) – *Can be free if hosted at NDoH*	R 6,000
Trainer	R 300 – R 1, 500

Example: MMC benchmark costs for expenditure on social mobilisation	
Transport (for trainee mobilisers)	R 2 875.00
Training manuals (printing) – *for max 25 people*	R 1,250.00
Certificates (design and printing) – *for max 25 people*	
Supply and maintenance costs for mobilisers. Include:	
Mobiliser tool kit (facilitator guide(printed), cap, t-shirt, name badge, pens, intake register, condoms)	R 1,160 p/m
Costed separately:	
T-shirt (short sleeves)	R 79 per unit
Caps	R 34 per unit
Name Tags	R 40 per unit
Training manuals	R 167 per unit
Umbrellas	R 125 per unit
Once off Cell phone purchase (for transmitting of intake registers from the field)	R 400 per unit
Printing of MMC DG pamphlets	R 0.56 per unit
Airtime for team leader and mobilisers	R 250 – 300 p/m
Employment costs. Include:	
Salary of Mobiliser (*can also be incentivised based on performance i.e. number of leads generated*)	R 4,600 p/m
Salary of Team Leader	R 12,840 p/m
Salary of Recruiter for social mobilisers	R 2, 000 p/m
Transport: Team Leader	R 2,000 p/m
Transport: Mobilisers	R 100 – R 500 p/m
District level support staff (i.e. portion of management, HR, finance, stakeholder engagement, M&E, admin etc.)	R 3,605 p/m

9.1.2. Call Centres

Call centres are complex and require significant infrastructure and resources to maintain. Ideally, there should be one call centre that is managed at the national level to ensure national coverage and scale as well as serve other health programmes. Outlined below are the various costs associated with the use of call centres for MMC demand generation. These costs include:

Training

As outlined in section 6, training of call centre agents is important to ensure that agents are well equipped to provide clients with correct and sufficient MMC information as well as adequately respond to questions posed by clients. There is often significant turnover in call centre agents. Training must take place for new staff and to refresh current staff where required. There are several call centres that are run and managed by different MMC implementers. For example, the call centre in Cape Town run by CareWorks, has all centre agents that are locally based or reside in or/around Cape Town. It is important to conduct training at a locally based training centre in order to limit costs related to i.e. travel and accommodation.

Call centres typically have a staff count of about 13 employees that work weekdays from 8am to 5pm and Saturday from 8am to 12pm. The call centre agents should be eloquent in all eleven official languages and trained to effectively express and communicate information related to MMC in all languages.

Supply and Maintenance

There are various service and maintenance costs that are associated with the use of call centres for MMC demand generation. These costs are related to maintaining equipment such as computers, phones and other office supplies. Service costs can include internet connection, SMS costs, airtime and call centre software that allow agents to manage incoming and outgoing calls as well as insurance. Supply and maintenance costs can be very expensive. These costs will vary according to different service agreements. It is important for implementers to always aim to bargain for better deals in order to minimise costs and ensure that there are strict policies in place for care and/or damage of equipment and also encourage employees not to waste resources.

Employment

These costs are related to the remuneration of call centre agents, managers and other support staff. The rates provided below are possible cost ranges and minimum costs that can be incurred for the employment of different staff on a monthly basis, unless stated otherwise.

Example: MMC Benchmark Costs for Expenditure on Call Centres	
Item	**Unit Cost**
Training Costs:	
Call centre trainer	R 6,000 p/m
Catering (x 3-day training)	R 100 – R 200 p/p
Transportation	R 300 – 1,500 p/m
Supply Costs:	
Call Centre Support (includes: telephonic & SMS booking support, reminders, confirmations, direct telephone costs (airtime), hardware/software, IS/IT programming & troubleshooting)	R 6,187 p/m
Telephone (for i.e. transmitting of intake registers	R 1,800 p/m
Employment Costs:	
Call centre agent	R 2,000 – R 6,000 p/m
Team lead/Supervisor	R 12,840 p/m
Support Staff (IS/IT programmer)	R 8,000 p/m

9.1.3. Activations

Section 6 of this document describes activations and their importance in generating demand for MMC. Activations can provide an opportunity for implementers to engage men on MMC using interactivity and the sharing of personal stories and experiences. When considering the use of activations, implementers should aim to initiate events that are aligned to the interests of the target audience. Possible costs that can be incurred for an MMC demand generation activation have been provided below.

Example: MMC Benchmark Costs for Expenditure on Activations	
Item	**Unit Cost**
Supply Costs:	
Venue hire (can be free depending on venue (NDoH) or type of event	R 2,700 – R 6,000 p/m
Media truck (with sound system/daylight screen)	R 50,000 p/m
Sound system (includes speakers, amplifier, transport and technical support for 1 x day)	R 1,500 p/m
Transport for equipment (includes crew and set up X 1 day)	R 1,000 p/m
Catering	R 100 – R200 per person
Printing of pamphlets	R 0.56 per unit
Design and printing of posters (estimated cost of printing 250 posters)	R 95 000
Gazebos, X2 tables, banners/bunting	R 8,800
Employment Costs:	
Presenter/host	R 500 per day
Supervisor/Event coordinator	R 3,000 per day
Celebrity/Champion	R 2,000 per day
Security guard	R 250 – R 500 per day

9.2. MASS MEDIA COMMUNICATION

9.2.1. Paid television advertising

In general, television campaigns are executed at a national level due to high cost.

Pre-testing

Pre-testing, as mentioned in section 6, is a critical part of the P-process and particularly important for television as production is expensive. It is important to ensure that the script is pre-tested with the target audience in at least two provinces to determine whether the target audience responds to the message and if revisions need to be made before production. This process can take six months to complete.

Production

This includes the cost for creative development, script writing, recording the advertisement, etc. This process can also take six months to complete.

Placement

The cost to air the television ad varies based on what broadcaster, what time the ad airs and who the specific audience is. Free-to-air TV is less expensive than DSTV and both target males and females aged 18-34.

Example: MMC Benchmark Costs for Expenditure on Television	
Item	**Unit Cost/month**
Pre-testing *(based on two districts in one province)*	R280,000 p/m
Production	
Placement *(national, based on two months with four bursts)*	R1,300,000 p/m **Free-to-air TV**: R0.32 * ~17.8M impressions = R5,700,000 **DSTV**: R0.70 * ~4.3 M impressions = R3,000,000

9.2.2. Radio

As discussed in section 6, community and regional radio can be an effective way to reach the target audience in some settings. Implementers that opt for this communication channel can place MMC adverts on radio or broadcast programmes on MMC. Often the costs associated with radio advertising include:

Operational Costs

These costs are related to placing adverts on radio and may vary across different radio stations. Radio stations base their charges on a number of factors i.e. the duration of the advert, the time of day and the number of times that an advert is aired. Implementers need to select an appropriate radio station that caters for the targeted age group as well as select the most appropriate time to air their advert.

In order to do this, implementers need to research and understand the preferences i.e. the times that the target audience is most likely to listen to radio and their language of preference etc. The research process also entails testing the advert to gauge how well it is received by the target audience. All these activities come at a cost. Some of the cost considerations of advertising on a local/community radio station have been provided in the table below. The cost of research will vary for different implementers. The radio advertising costs are based on ratings from Alex FM, a community radio stations that airs in Alexandra township, Johannesburg and the SABC Rap Studio rates for customized broadcasts.

Employment Costs

Implementers may need to pay for additional services provided by the radio station such as voice-over artists or a translator to translate scripts from English to the language of the target audience. These costs are dependent on the requirements of implementer and will again vary across the different radio stations.

Example: MMC Benchmark Costs for Expenditure on Radio	
Item	**Unit Cost**
Operational Costs:	
Research and Testing	R 3 800 per ad
Radio Production (includes 10 x themes, various accents, sound studio & engineer, music etc)	R 3,177 per ad
Placing 30 second radio advert (varies by day and time of the week)	R 400 – R 700 per ad

Administration fee	R 450 – R 750 per spot
Employment Costs: Voice-over artist to present advert (varies by months) Advert translator per language	 R 900 – R 3 080 per ad R 700 per ad

9.2.3. Print Media

Print is a good medium, as prospective clients can hold onto information and refer to it at a later time if they are interested in the content. When selecting a publication consider the language preference in the area and whether or not newspapers and magazines are in fact popular. If the general preference is towards listening to radio or watching television, rather invest budget there.

Ad placements in newspaper will vary by the size of ad and frequency of placement.

National newspapers are most effective when a part of an integrated public health campaign, such as Phila, possibly where ads are in the same location repetitively alternating through different HIV prevention and/or health-related messaging, including MMC.

Community-level newspapers are effective as the local clinic opening hours for MMC and address can be included. In addition, if timing for a mobile clinic is well-known it can be broadcast through community newspaper.

Example: MMC Benchmark Costs for Expenditure on Print	
Item	**Unit Cost**
Posters: Design and upload to publisher Placement	 R80,000 Varies by media outlet, date, location on page and size One-time insertions starting at: *National(37)*: R246 per square cm *Regional(38)*: R113 per square cm

Out-of-Home

Example: MMC Benchmark Costs for Expenditure on Out-of-Home	
Item	**Unit Cost/month**
Billboard Used at a local level can be used effectively in highly visible places to maintain awareness of MMC services or to highlight changes to a clinic's hours or address. • 1.5m x 3m • Metro township & non-urban Located inside taxi ranks/shopping nodes close to POS and key retailers around the taxi ranks and shopping centres	

Example: MMC Benchmark Costs for Expenditure on Out-of-Home	
Production Research and Testing Placement	R 930 p/m R 3,800 p/m R 1,430 p/m
Taxi Branding Wrapping a taxi can be effective along a commuter belt as the vehicle serves as a moving advertisement. Options include the back of a taxi or fully wrapping the vehicle (*see benefits of taxi back vs. full wrap in section 6)*. Price below illustrates full wrap Production Placement (4 months)	 R4,100/taxi R4,500/taxi
Commuter TV (adverts placed on TVs in taxis and buses): Purchased at a national level (15 sites) and is a highly visible to target audience • 30 seconds airing on TV Media buy includes running the spot/ad 32 times per day on either weekdays (20 days/month) or weekends (8 days/month)(39). If purchasing a longer duration (i.e. 2+ months), there is a monthly rate discount Production – *potentially coupled with another TV production* Placement (up to two months on weekday only)	 R140,000 p/m

9.3. DIGITAL AND SOCIAL MEDIA

Registration to most social media platforms is free, however to extract the most value social media, it must be constantly monitored and updated with new information for users to engage with. Social media also provides the opportunity to respond to queries/booking requests in real time, therefore the most important component is to ensure there is dedicated staff or person to monitor the various platform.

Social media has the benefit of being able to target very specific geographic locations, age, interests, etc. Sponsored ads aimed at the target audience vary in cost depending on platform. The cost of an ad depends on the level of desired reach, however social media ads tend to be lower cost than some traditional platforms.

9.4. IEC MATERIALS PRODUCTION

Posters and pamphlets

When considering posters and pamphlets, it is best practice to ensure these maintain a similar brand as well as look and feel so that people who see the poster relate to the pamphlet as well. This would also help reduce design costs, as designers would not have to develop a new creative execution for each format. Re-printing existing materials is the least expensive, however consider if there is material fatigue in the area, where new materials would be better received.

To determine print quantities, consider where the materials will be deployed most effectively in the community. Will the posters hang in taverns, shops, and other high visibility areas?

For pamphlets, consider the following:

- How many mobilisers (MMC, PHCWBOT, other) are in the area, as they hand out pamphlets on a daily basis.
- How many activations have been planned? This is important as that is a time where people are receptive to receiving material.
- Where can pamphlets be placed in the community where individuals will pick them up? i.e. clinics, churches, schools.

Example: MMC Benchmark Costs for Expenditure on Small Media	
Item	**Unit Cost**
Posters: Design and printing Placement	R 95,000 (estimated cost of printing 250 posters) R 2,500 per poster for 4 months
Pamphlet: Printing	R0.56 per unit

9.5. ADVOCACY

Advocacy for MMC can be an ongoing process that uses different channels to gain support from various organisations, institutions and/or constituencies. Engaging these various stakeholders can require constant interaction through meetings, information sharing and even media coverage. Some advocates may need to undergo training to learn about MMC and therefore implementers will need to consider some of the training costs tabled below. The overall costs for advocacy will vary depending on the different types of advocacy activities that are implemented. Some of these costs are related to hosting meetings, resource distribution and where possible employing an advocate on a full-time or temporary basis. To minimise costs related to employing an advocate, implementers can assume an advocacy role.

Example: MMC Benchmark Costs for Expenditure on Advocacy	
Item	**Unit Cost**
Training Costs: Venue hire for training – *Can be free if provided at NDoH* Transportation (depends on distance to training venue) Catering	 R 2,700 – R 6,000/day R100 – R 500 per person R 100 – R 150 per person
Supply Costs: Catering for meetings *Printing of IEC materials* Pamphlets Posters including design Stationery (note books, pens etc.)	 R 100 – 150 per person R 0.56 per unit R 95 000 (estimated cost of printing 250 posters, including design) R 50 per package

Employment costs: Salary of advocate	R 12,840 p/m

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